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The
JOURNAL
of Addiction and
Mental Health

A PUBLICATION OF THE
CENTRE FOR ADDICTION
AND MENTAL HEALTH

September/October
1998
Volume 1
Number 1

Individuals Reading Room
Humanities & Social Science 219

Concurrent Disorders.

Innovations
in treatment,
screening and
integrated programs.



Centre
for Addiction and
Mental Health
Centre de
toxicomanie et
de santé mentale

COMMUNITY TREATMENT ORDERS

Research shows they have
little short-term effect

A FOOD GUIDE FOR USERS

Few addictions programs
teach healthy eating

FAITH OR CHEMISTRY?

The debate on why
antidepressants work



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Cover

"Night and Day"
by Michael Alzamora
acrylic on canvas
36"x 48"

Michael Alzamora is a Toronto artist. "My doctor says one can become mentally ill — in my case, with schizophrenia. Although schizophrenia is very debilitating, one thing that it doesn't impair is creativity. This painting is part of my creative process. It's my trademark to use egg clouds and rolling sheets for water and the ground. The best way to put it is that it's a window to my imagination."



News from the Centre

Created to improve access to quality services for mental illness and substance use problems, the Centre for Addiction and Mental Health was formed in early 1998 through the amalgamation of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute and the Queen Street Mental Health Centre. The Centre is a teaching hospital fully affiliated with the University of Toronto. The Centre's fully-integrated mandate — research, education and clinical care — is focused on improving the understanding, prevention and care of addictions and mental illness.

As the largest mental health and addictions facility in Canada, we now have a strong voice to ensure that services are accessible, effective and adequately funded. The Centre provides a continuum of clinical programs, support and rehabilitation to meet the diverse needs of people who are at risk and at different stages of their lives and illness — from children to the elderly. In accordance with our provincial mandate, the Centre plays a vigorous role in consultation, policy development, education, training and research at the local level in communities throughout Ontario.

The merger has brought together scientists who are examining the physiological, psychological and social dimensions of addiction and mental illness. And we are committed to ensuring that what we learn is translated into programs, services and resources for use in communities across Ontario, Canada and internationally.

In the very short time that we have been operating as one organization, we have:

- adopted a program management model that will result in improved planning, better allocation of resources and better patient care
- produced a range of administrative savings that will be reinvested in programs
- developed a full spectrum of integrated treatment services and a Concurrent Disorders Training Program for care providers working in community agencies
- increased our reach by forging formal collaborations with St. Michael's, Sick Children's, Mount Sinai and Women's College Hospitals, and
- integrated and expanded our much-needed forensic services.

Downloaded

"...even the most comprehensive search engines index no more than 40 per cent of the 320 million easily accessible web pages." From: a recent study by the NEC Research Institute reported in the August 1998 issue of **Information Outlook**, the magazine of the Special Libraries Association (SLA), available at <www.sla.org>.

All the more reason to read this column! Here are three sites to bookmark, if you haven't already.

Canadian Mental Health Association -

Editor's message

Welcome to the new Journal of Addiction and Mental Health, the only magazine exploring issues in addiction and mental health in Canada.

This magazine is an exciting step in the life of the new Centre for Addiction and Mental Health. The Centre formed earlier this year through the merger of the Addiction Research Foundation, Clarke Institute of Psychiatry, Donwood Institute and Queen Street Mental Health Centre.

One of the many tasks the Centre faced was to develop a new publication that would provide information and news important to the addiction and mental health fields. To accomplish this, we asked our potential readers — people like yourself, such as professionals, clients, consumers and family members — about the type of publication you'd like to see, through a readership survey. The Journal of Addiction and Mental Health is the product of more than 600 survey responses and endless hours of research and consultation.

The result shouldn't be too much of a surprise as almost everything, beginning with the cover idea and name, and including the concept of the publication itself, came out of the surveys.

The cover is graced by a painting by artist and consumer Michael Alzamora, who is becoming quite a success with his work in the Toronto area. As for the contents, a clear majority of survey respondents said they wanted a magazine-style publication that covered developments in the addictions and mental health fields, but also felt it was important to focus on a particular topic in detail.

We've combined the two concepts into one package. Our news section reports on topical and relevant developments in the addictions and mental health fields. In this issue, our focus section offers a series of articles on concurrent disorders, including a Question and Answer column.

Within the magazine, you'll also find regular features that rated highly on our survey, including research summaries and conference listings.

And we've left room for opinion and dissent near the end of the magazine in "The Last Word." We encourage you to submit ideas for guest editorials in future issues to promote debate.

But now that we've done our work, it's your turn again. Tell us how we did, and what we could do better. Write a "letter to the editor." Give us a phone call. Keep in touch. We want to make this publication increasingly relevant to ensure that it accurately reflects what the field needs.

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www.icomm.ca/cmhacan

Find an array of resources including up-coming events, policy statements, full text project documents such as **Mental Health Promotion: A Framework for Practice**, and links to CMHA branch sites.

Substance Abuse & Mental Health Services Administration - www.samhsa.gov

This much improved and expanded U.S. agency site provides a gateway to substance abuse and mental health information through its resources and links to its programs sites: Centre for Mental Health Services, Centre for Substance Abuse Prevention, etc. Some highlights: grant information, reports for large

scale U.S. research projects and access to **SAMHDA**, a searchable data archive from many key U.S. surveys and statistical reports.

Institute for Mental Health Initiatives - www.imhi.org

The mandate of this non-profit organization of mental health professionals is to promote emotional well-being at the grassroots level by making mental health research available to the media and public. Check out its award-winning newsletter **Dialogue**. Each issue deals with a topic clearly and effectively. Some recent topics: **Drug Abuse, Women and Work, Mature Women, Teens and Risk**. SHEILA LACROIX

In Brief



Body pain and mental illness

Fibromyalgia — a common cause of widespread body pain — is linked to psychiatric disorders, a study from the University of Iowa suggests. The study compared first-degree relatives of people with fibromyalgia with a control group of relatives of people with rheumatoid arthritis, a condition in which fibromyalgia is also often present. They found that psychiatric disorders occurred more frequently in family members of fibromyalgia than in the control group. Results were presented at the American Psychiatric Association conference in August.

LCBO safe for now

The Ontario government has no plans to privatize the province's Liquor Control Board for now, reports the Canadian Press. During the 1995 election, the Conservatives promised to sell the LCBO and commissioned a report on the issue that was completed recently. However, the government did not rule out the possibility that privatization could happen in future.

Drug tests discriminate

The Toronto-Dominion Bank's drug testing policy for new employees is discriminatory, the Federal Court of Appeal ruled in July. The policy violates the Canadian Human Rights Act because finding traces of drugs isn't sufficiently related to job performance and doesn't suggest an

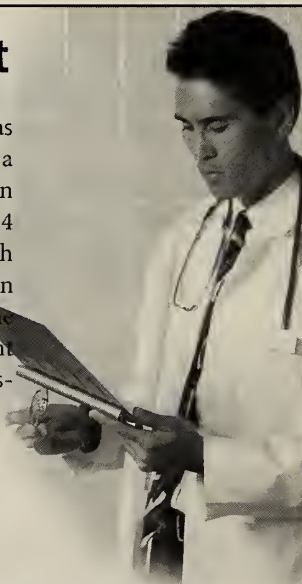
employee will commit a crime at work, the court said. The Canadian Civil Liberties Association filed its original complaint with the Canadian Human Rights Commission in 1991, a year after the policy was implemented. The bank is considering an appeal to the Supreme Court.

Caregivers depressed

Many family members caring for people with schizophrenia are close to experiencing clinical depression because of the stressful demands on their life, a new study by Consumer Health Sciences and the U.S. National Mental Health Association found. Researchers gathered information from 1,328 family caregivers and 879 patients with schizophrenia. Almost a third said that the emotional and behavioral symptoms of the illness cause their distress. More than half indicated that drug abuse, suicide threats and violence also create constant anxiety, even though they don't necessarily affect them daily.

Docs judgment inconsistent

How well do psychiatrists assess whether depression has affected the capability of a patient? Inconsistently, suggests a study presented at the American Psychiatric Association Conference in Toronto in August. Researchers surveyed 54 psychiatrists, giving them six hypothetical scenarios in which patients refused life-saving care. In a case where the person had a history of depression, 66 per cent of doctors found the patient competent, 21 per cent incompetent, and 13 per cent did not know. In the cases where a person had major depression, about a quarter found the patient competent.



Official call for heroin trial

Senior officials in British Columbia are calling for an immediate expansion of methadone programs and for a controlled heroin prescription trial, in the wake of more than 200 heroin-related deaths in the first six months of 1998. The province's chief medical officer, a Vancouver member of parliament, the city's top coroner and the police chief have all publicly supported spending more money on treatment. MP Libby Davies plans to form a political coalition to support heroin prescription, which would stabilize users, reduce health risks from overdose and HIV infection, and keep them in contact with social service providers. A North American Heroin Prescription Trial Working Group met earlier this year to discuss the idea. The federal government would have to authorize any heroin prescription trials.

Youth gambling skyrockets

Between five and eight per cent of Canadian and U.S. adolescents have a serious gambling problem, new studies suggest. This compares with rates ranging from one to three per cent among adults, according to researchers at Montreal's McGill University and the University of Minnesota, who presented their results at the American Psychological Association meeting in August. McGill

researchers found that 35 per cent of adolescents gambled at least once a week, and that the gamblers were far more likely to drink alcohol, smoke cigarettes or consume drugs. Males preferred sports lottery tickets and betting pools, while females were more likely to buy lottery tickets and play bingo. McGill is running a pilot project to treat gambling problems among adolescents.

A genetic link to schizophrenia

An international team of researchers has found strong evidence of genetic susceptibility to schizophrenia. Their study isolated the location of the genes on a stretch of human chromosome 13. Researchers studied the DNA of more than 50 families, repeating their study with a second set of families. The study, reported in *Nature Genetics* in August, also suggests that different genes may be responsible for the condition in different families. Most experts agree that schizophrenia is influenced by both genes and environment. Schizophrenia affects about one per cent of the population.

The Prozac versus placebo debate

Faith, not drugs, helps conquer depression, researchers say

Is the effectiveness of antidepressants a function of chemistry or faith? Mostly faith, according to Drs. Irving Kirsch and Guy Sapirstein, who contend that 75 per cent of the beneficial effects of antidepressant medication can be ascribed to placebo effect — the strong belief that the drugs work — and only 25 per cent to actual changes in brain chemistry.

Dr. Kirsch, of the University of Connecticut, and Dr. Sapirstein, of Westwood Lodge Hospital, Needham, drew their conclusions from a meta-analysis, analyzing data from 19 randomized, placebo-controlled studies involving 2,318 patients being treated for depression with either antidepressants or placebos.

Their findings, published in the American Psychological Association's new electronic journal *Prevention & Treatment*, have fuelled an already-heated debate about the effectiveness of antidepressants.

But regardless of where they fall in the debate, all sides concur on two facts: antidepressants do work and, like virtually all medications, they have placebo effects. The debate is not really about whether they work, but why.

Psychologist Dr. Zindel Segal believes that powerful psychological processes such as expectation, belief and credulity influence results of antidepressant treatments. Rather than couching these influences as "placebo effect," Segal views them as part of the mechanism of the action of these drugs.

nism of the action of these drugs.

The debate is not a turf-war between psychology and psychiatry, feels Segal, head of the cognitive behavioral therapy unit at the Centre for Addiction and Mental Health. Rather, he sees it as a conflict between pharmaceutical companies who are working to market their products, and scientists who are working to understand how factors such as expectation and belief interact with chemical changes in the brain to relieve symptoms.

"Drug companies have promulgated a straightforward view of depression as a physiological problem requiring a physiological treatment," says Dr. Segal. While this emphasis has helped destigmatize depressive illness, he believes it has excluded the potential to include psychological processes in explaining how these drugs produce beneficial effects.

Regardless of why antidepressants work, pharmacist Kalyna Butler believes Drs. Kirsch and Sapirstein's argument is based on questionable science.

In the studies they drew from, there were different levels of illness severity, as well as different drugs, dosage levels, durations of drug use and measures of response, says Butler, primary editor of the *Clinical Handbook of Psychotropic Drugs*. In studies that used active drugs rather than placebo as comparisons, the drugs used had some antidepressant actions in

three out of four cases.

Butler also points out that some studies didn't follow subjects for long enough. "Clinically, you need four to six weeks before you determine the effectiveness of a drug," she says.

Dr. Sid Kennedy, who heads up the Centre's Mood and Anxiety Disorders Program as well as the Mood Disorders Program at the University of Toronto, believes that while meta-analyses are often the only means of gathering large pools of data, they do have limitations.

"Meta-analyses assume a level playing field," says Dr. Kennedy. "But a small study with a strong placebo effect is given the same weight as a larger study with a smaller effect." And clinical trials in the meta-analysis do not necessarily reflect how antidepressants perform in routine clinical practice. "Everyone [in clinical trials] receives a good deal of attention and practical assistance which amounts to a form of supportive therapy — so even those on placebo are really receiving active treatment," he says.

This seems to bear out the assertion that the power of the mind, may be as good, if not better. Then how can prescribing antidepressants be justified if the value-added effect seems so marginal?

"I can't agree they have a marginal effect when you see so many lives dramatically changed for the better," says Kennedy. "Forget the 25 per cent figure and think for a minute about people. Even when you set the most rigorous criteria for full recovery, in 30 to 40 per cent of cases, antidepressants lead to a dramatic functional recovery."

Prevention & Treatment is on the Internet at <journals.apa.org/prevention/>. KATE COWEN

Gambling's impacts

THE INCREASE IN LEGALIZED gambling opportunities across Canada has led to a surge in research looking at their impact on communities.

The most recent casino announcement came from British Columbia, where the government approved in principle four "destination" casinos. Three other casino licences were granted in May in B.C., and the government is considering seven more. Over in Ontario, the government nixed its plan for 44 permanent charity casinos and instead approved larger-scale casinos for Thunder Bay, Sault Ste. Marie, Brantford and Point Edward.

In one of the first studies of its kind to gauge the impact of casinos, researchers from the

Centre for Addiction and Mental Health polled community members in Niagara Falls before and a year after the Niagara Falls Casino opened in 1996. The number of residents reporting problem gambling rose from 2.5 per cent to 4.4 per cent, and public perceptions about the positive impacts such as increased property values and profits for non-casino related businesses had not been borne out. However, the study also showed that concerns about negative impacts, such as increased crime, had also been unwarranted. And though the community had harbored concerns about the Casino prior to its opening, public support for it had increased slightly in the year since it had opened.

In a similar vein, the 1997 Canada West Foundation (CWF) study "Gambling and the Public Interest" which compared data on the

recent growth of gambling to its social costs, found that it was not the promised "quick fix for funding non-profits, creating jobs, boosting local economies, keeping taxes low and augmenting government coffers." The study found that although the financial benefits of gambling are readily ascertained, "the social costs of the activity are often hidden."

The CWF has also begun to collect data for its three-year study "Gambling in Canada: Triumph, Tragedy or Trade-off?" It will examine factors such as gambling revenue, costs and prevalence. The study seeks to understand the full effect of gambling on communities, and of the conflicting interests between revenue generation and increased social costs inherent when governments get involved in gambling. CHRIS HENDRY

Impaired drivers sentenced to get help

STARTING THIS FALL, CONVICTED impaired drivers in Ontario will be required to attend either an education or treatment program before their drivers' licences can be reinstated. Similar programs have contributed to significant drops in drinking and driving in Manitoba and other jurisdictions.

Ontario's "mandatory remedial measures" program is the centrepiece of changes to the province's drinking and driving laws passed in July 1997, as part of the *Comprehensive Road Safety Act*.

A related change increases the mandatory licence suspensions for first, second and third drinking driving convictions to one year, three years and life, with the possibility to reapply after 10 years. Both changes were scheduled to come into effect at the start of October.

Ontario's remedial measures program includes four major components:

- a standardized assessment to separate "low risk" offenders from those at high risk of re-offending
- an educational program, delivered either over a full day or in four evening sessions
- a treatment program for high-risk offenders, focusing on self-monitoring, identifying personal risk situations and practising coping strategies
- a participant-initiated telephone follow-up interview six months after their course.

The Addictions Foundation of Manitoba (AFM) administers its province's mandatory

Impaired Driving Program, which includes an assessment and a range of options, including "no further action," and education and treatment interventions. Since it was launched in 1986, recidivism rates have dropped steadily, said the AFM's Darleen Golinowski. A recent Health Canada evaluation of the Manitoba program found recidivism rates of 24 per cent for the treatment group and 12 per cent of the "no further action" group.

Elements of Manitoba's program are being adapted for Ontario's program, which is being developed and delivered by the Centre for Addiction and Mental Health under a contract monitored by the Ministry of Health. Services will be delivered by designated treatment agencies in more than 100 locations across the province. The program will be funded entirely through the user fee charged to each participant.

"There is very strong evidence that, when they are done right, these programs can reduce drinking/driving recidivism, alcohol-related collisions, injuries and fatalities, and health measures in general" said Bob Mann, a senior scientist with the Centre.

A 13-year follow-up study of drinking drivers in two Ontario cities, carried out by the Centre's Addiction Research Foundation Division, found that those referred to rehabilitation programs had a mortality rate 30 per cent lower than those

who receive no treatment.

Because repeat offenders account for almost 70 per cent of the more than 20,000 licence suspensions issued in Ontario each year, reducing recidivism is a key goal. In California, an evaluation of court-ordered interventions found that impaired drivers who had their licences suspended and were ordered into treatment were half as likely to re-offend as those who were sentenced to jail only.

Doug Bierness, vice-president of Ottawa's Traffic Injury Research Foundation, is cautiously optimistic about the Ontario program. "Screening and treatment is definitely the way to go" to deal with repeat offenders, he says.

However, Bierness is concerned that the new lifetime suspension may end up undercutting the program by inadvertently prompting third and subsequent offenders to drive illegally, rather than seeking treatment and having their licences reinstated. "A lot of these people are going to drive anyway," he says. "A better approach would be to offer them some incentive to go to treatment and prove they are under control." **MYLES MAGNER**



Consumer participation key to recovery

Before I looked at a society in which I wasn't accepted, and therefore felt I didn't have to participate, but since I've been in recovery... it has totally changed my way of thinking.... To be part of that community is a healthy way for my recovery to blossom. — Kenneth

For many people with serious mental illnesses, the road to recovery is plagued with obstacles — one of which is finding a meaningful and rewarding place in society. Kenneth, quoted above, belongs to the Ottawa-Carleton Branch of the Canadian Mental Health Association (CMHA), and his statement points to the success of the CMHA's Inclusion in Community Project.

For the past two years, the inclusion project has been trying to connect people recovering from mental illnesses with their communities, and to "help service providers make the shift from thinking in terms of *providing services* to thinking in terms of *promoting community integration*."

Eight diverse communities throughout Canada were chosen to implement the projects, funded by Health Canada and Ontario's

Trillium Foundation. The CMHA required that "all policy development and program delivery should start by listening to consumers."

Each community had to decide what inclusion meant, and how to get consumers to formulate and implement their own programs. CMHA service providers guided the process in most locations, but did not direct it.

For example, a consumer committee in Ottawa-Carleton developed a peer inreach program that saw recovering consumers meeting with those newly discharged from the hospital to connect them with community resources.

"The fact that I'm able to do volunteer work makes me feel that I have something to contribute," says Trina. "It's almost like that validates me — I'm OK, somebody needs

something from me."

Community work also combats what many projects identified as the biggest obstacle to community acceptance: a societal stigma attached to recipients of mental health care.

The team in Truro, Nova Scotia, developed a plan designed to reduce that stigma. They started a muffin-baking business staffed, organized and run solely by consumers. Almost all customers are connected to mental health care organizations, but Dawn Adams, who heads the project, hopes they can expand out into the community.

As a whole, the national program represents a departure from traditional mental health techniques. A report by the Ottawa-Carleton Branch explains: "The previous almost exclusive reliance on medical/clinical knowledge to explain and deal with mental illness is changing." Instead, the experiences of consumers and their families are being tapped to show how successful community inclusion is so closely linked to recovery from serious mental health problems. **EZRA HOUSER**

Treatment orders show mixed results

U.S. researchers study the contentious issue

Researchers in North Carolina have finished one of the only studies on the effectiveness of community treatment orders. Their findings that treatment orders have little short-term effect in reducing violence and hospitalizations will likely influence debate in Ontario over the already contentious issue.

Community treatment orders consist of court-ordered regulations which allow psychiatric patients to live outside a hospital setting, in return for accepting compulsory community-based treatment. Patients who fail to comply with treatment might end up committed to an institution.

Community treatment orders emerged as a hot topic of debate in Ontario after the Ministry of Health (MOH) launched a review of mental health services in June 1997.

Researchers at Duke University examined how effective community treatment orders — or “involuntary outpatient commitment” in the United States — were in reducing violence and hospitalization among psychiatric patients.

A total of 331 severely mentally-ill patients who were being released from mental hospitals

participated in the one-year study. These patients had been ordered by the courts to receive outpatient treatment. For the terms of the study, half the patients were released from their outpatient commitment orders and only received case management. The other half received case management and community treatment services.

For the short-term, “there was no difference in hospitalization rates or violent behavior” among patients released into community treatment programs, versus those released solely into case management, says Dr. Marvin Swartz, head of the division of social and community psychiatry at Duke University.

Consumers who remained in sustained community treatment programs for longer periods, such as six months, did experience “fewer hospitalizations and fewer violent incidents,” however. This was only the case, though, when patients experienced a high level of treatment services. “Sustained outpatient commitment had no effect in the presence of low-level services [and treatment],” he says.

Dr. Swartz released his findings this July at a meeting of the International Congress and Law and Mental Health in Paris, France.

Ontario’s mental health field has been considerably more opinionated. The Canadian Mental Health Association (CMHA) opposes community treatment orders, while the Schizophrenia Society of Ontario supports them.

“We recognize that there are individuals in the community who lack insight into their disorder,” explains Janice Wiggins, executive director of the schizophrenia society. “You have to take into account the incapacity of some very sick people.” The CMHA, Ontario Division, meanwhile, have written a nearly 50-page policy document explaining why they oppose CTOs. “Community treatment orders could result in unwilling participants having to participate in community programs, to the possible detriment of the client, other clients and the program,” reads the paper.

The provincial government is keeping close-mouthed about the subject. The MOH has “no official position regarding community treatment orders,” says Jeremy Adams, spokesperson for Health Minister Liz Witmer.

At present, Saskatchewan is the only province in Canada where orders can be issued. **NATE HENDLEY**

U.S. anti-drug ads

WITH GREAT FANFARE, U.S. President Bill Clinton, the White House Office of National Drug Control Policy (ONDCP) and the Partnership for a Drug-Free America (PDFA) launched a new anti-drug media campaign in July.

Billed as the largest media campaign ever undertaken by the U.S. government, the five-year project includes \$2 billion in private and public funding that will pay for an unprecedented exposure of anti-drug messages aimed at both youth and adults. The messages are currently appearing on television and radio and in newspapers.

However, the campaign has renewed the debate over whether media campaigns with prevention messages actually work.

“We can cut the demand for illegal drugs among our children, and this campaign will help us do so,” says James Burke, chairman of the PDFA, quoted on its web site.

Can a mass media campaign actually change drug-taking behavior? The evidence suggests that it can’t.

Brandweek, an advertising industry trade journal in the United States, recently took a hard look at the claims made by PDFA and

ONDCP (April 27, 1998 issue). The magazine found that the foundation for the past and current advertising campaigns by these organizations rest on just three research studies — two of which have never been published. The one study that was published simply reported what respondents said after viewing anti-drug messages. The researcher told *Brandweek* that she suspects respondents told her what they thought she wanted to hear.

Also, as *Brandweek* found out, the advertising agencies working on the U.S. anti-drug campaign do little or no research at all. “While ad agencies’ good intentions are as true as any other partner... most are also too taxed to put the same level of rigorous research and account planning into a PDFA ad that they might for a paying client..... Most agencies, in fact, view the experience as merely a creative exercise in the name of good citizenry.”

Angela Paglia, a researcher at the Centre for Addiction and Mental Health, doubts that a media campaign, even one as big as this, will work by itself. She co-wrote a literature review on research into preventing substance-use problems among youth.

Can You Find The Drug Dealer In This Picture?



“It is naive to think that it alone will change behavior,” she says. “Media campaigns are most effective when delivered in tandem with other components, such as policy changes and other community interventions.”

Paglia found that most experts agree the mass media are most effective when they are used to set the public agenda. For example, public service announcements on drinking and driving help set the stage for both changes in public attitudes and changes in law.

In her paper, Paglia recommends using multiple media to promote a lifestyle norm or stimulate discussion about an issue. She cautions that campaigns have to walk a fine line — and avoid fear and moral messages. **CRAIG SMITH**

Helping moms with schizophrenia

A GENERATION AGO, WOMEN WITH schizophrenia were unlikely to be mothers. Up to the 1950s, they probably lived in an institution, where their chances of marrying were slim, sex was forbidden and medications dampened their sexual desires.

But times changed in the 1960s and 1970s, with deinstitutionalization, relaxed sexual mores and new medications.

Now, women with schizophrenia are having babies with the same positive expectations as any mother — but as many as two-thirds lose custody of their kids to foster care, according to Dr. Laura Miller, associate professor of psychiatry at the University of Illinois at Chicago.

Dr. Miller and her colleagues run an award-winning Parent's Clinic that helps women with schizophrenia-related disorders become better mothers, so that they're more likely to retain custody of their kids.

Their research on women with schizophrenia points to a need for more sex education, HIV screening, and assessment of parental skills, ideally incorporated into mental health care for accessibility.

"Hospitals and clinics don't assess a woman's ability to parent, or their understanding of family planning," says Dr. Miller who spoke at the Tapscott Lecture at the Centre for Addiction and Mental Health in August. "Women are usually referred out, but outside referrals often won't stick."

The researchers found that a group of 46

women with schizophrenia was less likely to receive prenatal care than a control group of 50 women matched for age, race, education and other social factors.

Although both groups were equally sexually active, women with schizophrenia had more partners, exchanged sex for money and engaged in risky behaviors more often. They were also less likely to be screened for HIV or to know about birth control, said Dr. Miller. Not surprisingly, their pregnancies were more likely to be unplanned and unwanted.

Yet for many women with mental illness, their role as a mother is equally or more important than having a paid job, Dr. Miller and her colleagues noted in *Psychiatric Services* (v.47, #5). This is not reflected in the type of support available for the parenting role, unlike vocational rehabilitation which is recognized as an important part of treatment.

Women with schizophrenia do need special attention to help deal with the additional effects their condition has on pregnancy and childbirth. Swedish researchers have found that about 60 per cent of women report aggravated mental health problems during pregnancy, and they also have more acute postpartum symptoms after giving birth than the control group.

Other studies suggest that babies of women with schizophrenia are more difficult, and have slower mental and motor development. The mothers are also less likely to discern non-verbal and facial expressions in their babies



and touch their babies less. Socially, the women have fewer support networks.

In an earlier study by Dr. Miller, a few of the women denied they were pregnant, refused care and later claimed they had not given birth or their babies were defective. "I feel their behavior, as part of their psychosis, reflects their fear of losing custody of their children," she says.

Custody decisions for women with schizophrenia are sometimes based on exceptionally high standards of parenting. Dr. Miller says that neglect or abuse are unacceptable, but otherwise staff will build on existing parenting skills.

In the Parent's Clinic, women use each other as experts, seeking ideas, help and support at a weekly peer clinic, with a nurse facilitator guiding discussion. Dr. Miller feels this approach has helped at least a few mothers retain custody of their children. **ANITA DUBEY**

Exploring the joys of drinking

Pleasure is a neglected area of research

When the effects of alcohol are described in the public health arena, it is normal to hear words like "risk," "harm" and even "violence." Is it useful or responsible to discuss the effects of alcohol on health in terms of pleasure? Exploring that question was the focus of the recent "Permission for Pleasure" conference in New York City, which was organized by the alcohol industry-sponsored International Centre for Alcohol Policies (ICAP).

The goal of the conference was to "bring together existing knowledge on the role of pleasure in drinking, and further, to determine whether that concept is useful for scientific understanding as well as policy consideration," said conference organizer Stanton Peele in his opening address.

Sessions such as "The Meaning and Significance of Pleasure" highlighted the fact that worldwide, alcohol not only plays a significant role in many social, ceremonial and religious contexts, but that most people who drink do so responsibly and in moderation. In contexts where alcohol use is accepted, it is readily linked with pleasure. Rather than taking that linkage as trivial, a growing number of researchers and policy-makers regard pleasure as a phenomenon that deserves serious attention.

"Pleasure is clearly a neglected area of research. To understand the harms [of drinking] it is essential to understand pleasure," notes Eric Single of the University of Toronto. He spoke on the role of the setting in which people drink, and on patterns of drinking —

shifting the focus from how much alcohol is consumed, to how it is being consumed and why. Single adds that taking pleasure seriously does not commit one to holding that "the benefits [of drinking] outweigh the risks."

Including the dimension of pleasure in public health will lead beyond restrictive, prohibitionist attitudes towards alcohol, which impede forthright education about what is pleasurable and what is dangerous drinking, says ICAP president Marcus Grant. With reference to the high U.S. legal drinking age, Grant argued that, "We need to teach complex skills. We need to teach our children and inform them so that they, too, can grow up prepared to make choices. Certainly, drinking sensibly is not a skill that drops into young adults' laps the day they turn 21."

Peele noted with disappointment that few American public health representatives attended. "Taking pleasure as a theme [is] beyond the normal ken of academic researchers," he speculated. **ANDREW JOHNSON**

Poor care for schizophrenia

A U.S. study gave poor marks for the quality of treatment that many patients with schizophrenia received at two public mental health clinics. After developing a standardized criteria to measure quality of care, researchers studied medical records and interviewed 224 patients at the clinics over a three-month period. Overall, 38 per cent experienced poor medication management, and 52 per cent had inadequate psychosocial care. Examples of poor care were neglecting to make changes in medications over a long period, or a failure to

deal with symptoms or side effects of medication. Psychosocial care was rated poorly if clinicians had not been in contact with a case manager or family member in the past three months, in cases of severe illness. "At a clinical level, this study suggests that programs providing care for schizophrenia should consider measuring and improving the quality of the treatment they provide," researchers say. **A.D.**

Archives of General Psychiatry, v. 55, 611-616.

Alexander S. Young et al., Dept. of Psychiatry and Centre for Health Services, University of California, Los Angeles.

Help caregivers

Caregivers who receive emotional, social or practical support and who can keep working if they want are less likely to be stressed, a literature review suggests. In examining caregivers' mental health, researchers found that spousal caregivers were more likely to be depressed than adult children, while daughters-in-law were the most vulnerable to stress. The signs that caregivers might experience a mental disorder were if their loved one had behavior disruptions, if they were female, or if they had to change work hours. In fact, 78 per cent of those who worked said they preferred the dual role to earn money, be less isolated socially, and boost their self-esteem. Most of this group were older women working part-time in the lowest income bracket. A study found that caregivers who were offered structured support delayed admitting their loved ones to a nursing home by one year, compared to a control group. **A.D.**

Current Opinion in Psychiatry, v. 11: 431-434.

Lisa P. Gwyther et al., Duke Alzheimer's Family Support Program, Duke University Medical Centre, Durham, North Carolina.

Alcohol screen misses gender differences

Significant gender differences detected in the Self-Administered Alcoholism Screening Test (SAAST) call into question the validity of the test when screening women. In a study of 1,920 men and 1,775 women referred to a clinic for alcohol-related problems, responses to some parts of SAAST revealed fundamental differences in how women perceive their drinking relative to men. For example, men attributed seeking psychiatric care or entering a hospital to alcohol-related problems. Women were more comfortable with a "psychiatric" or "emotional" label as opposed to one as a drinker. Results suggest that the same questions should not be used for both sexes in screens, and that women may be more likely to appear with their problems in a general medical setting, the authors indicate. **P.H.**

Journal of Clinical Psychology, v. 54:439-445. Lisa M. Allen et al., Pacific Graduate School of Psychology, Palo Alto, California.

Stress disorder undetected

Post-traumatic stress disorder (PTSD) was significantly under-detected in a population of severely mentally ill patients who had not previously been diagnosed with the disorder. According to a multi-site, U.S. survey of 275 patients, 43 per cent had PTSD. Yet only three out of these 119 patients with PTSD had this diagnosis in their charts. Ninety-eight per cent reported being exposed

to at least one traumatic event over their lifetime, while most experienced an average of 3.5 different types of traumatic events. Men and women were equally likely to be exposed to the same number of traumatic events. Women were more likely to be sexually abused than men, both as children and adults, while men were more likely to have been attacked with a weapon and to

have witnessed violence. Failure to diagnose PTSD in the seriously mentally ill could have important implications, possibly enhancing social isolation because of related avoidance behaviors, and increasing susceptibility to substance abuse, researchers say. **P.H.**

Journal of Consulting and Clinical Psychology, v.66(3): 493-499. Kim T. Mueser et al., Department of Psychiatry, Dartmouth Medical School, Concord, New Hampshire.

Exercise cuts fatigue

A graded exercise program used to treat chronic fatigue helped improve fatigue, functional work capacity and confidence among patients after 28 weeks of therapy. The study randomly placed 136 chronic fatigue patients in one of four groups: exercise and 20 mg of fluoxetine (Prozac) daily; exercise and placebo; therapy and 20 mg of fluoxetine daily, or placebo. Those with the graded exercise program experienced a 10 per cent improvement on functional work capacity, and there was a 12 per cent reduction in the number of patients reporting fatigue by 26 weeks. In contrast, fluoxetine had no effect on either functional work capacity or fatigue scores. The authors suggest that graded exercise may help reassure patients that physical activity does not necessarily make them more tired, so they are willing to attempt other activities. **P.H.**

British Journal of Psychiatry, v.172, 485-490. Alison J. Wearden et al., Department of Psychiatry, University of Manchester, United Kingdom.



Fetal alcohol babies may risk addiction as adults

Additional fetal alcohol risks

Exposing a fetus to alcohol may increase the likelihood that the baby will become dependent on alcohol or other drugs as an adult, one of the the first studies of its kind suggests. Researchers found that fetal alcohol exposure increased adult symptoms of drug, alcohol and tobacco use — even after controlling for gender, environmental effects, genetic risk and other factors. Out of 197 adoptees interviewed for substance abuse disorders, 21 had mothers who drank during pregnancy. Substance abuse symptoms

were lowest in people who had not been exposed to alcohol before birth, and the highest counts occurred among those who definitely had been, the authors state. Separating effects of genes from fetal exposure on substance abuse “can provide further knowledge of the pathway of risk for substance abuse and the effect of specific prevention strategies,” the researchers suggest. **P.H.**

Alcohol: Clinical and Experimental Research, v.122 (4): 914-920. William R. Yates et al, Dept. of Psychiatry, University of Oklahoma College of Medicine, Tulsa, Oklahoma.

Smoking linked to Alzheimer's

Smokers are twice as likely to develop Alzheimer's disease and dementia as non-smokers, according to a Dutch study. Researchers examined 6,870 people aged 55 and older in a Rotterdam suburb who initially did not have dementia. Using interviews and medical records,

they assessed smoking status, health, education, alcohol intake and other factors. During follow-up about two years later, 146 cases of dementia were detected, of which 105 were Alzheimer's disease. Researchers found that smokers tended to develop dementia earlier than nonsmokers,

that former smokers were also at slightly higher risk than those who had never smoked, and that men had a greater risk than women. **A.D.**

Lancet v. 351: 1840-43. A. Ott et al, Departments of Epidemiology & Biostatistics, Erasmus University Medical School, Rotterdam, Netherlands.

Heroin trial benefits

Severely-dependent opiate addicts stopped using street heroin, improved their mental health and social functioning, and cut down on illegal behaviors in a heroin maintenance program, a preliminary Swiss study found. Users who had failed in at least two previous programs were randomly assigned to a treatment group that received heroin up to three times a day, along with other social services, or to a control group that could chose any conventional treatment, including methadone. After six months, only one person

of 27 in the heroin group still used street heroin, while almost half of the 24 in the control group did. There were no changes in terms of housing, work, or use of other drugs between the groups. Researchers recognized that their study did not tease out the effects of prescribed heroin over other medical and social services, but noted that such programs alone do not retain users in treatment. **A.D.**

British Medical Journal, v. 317, 1998, 13-18. Thomas V. Perneger et al., Institute of Social and Preventive Medicine, University of Geneva Medical School, Geneva, Switzerland.

Laxer pot laws

While most of the Australian university students in a survey said they'd grow more cannabis if penalties were reduced, a majority also stated their personal consumption wouldn't increase. Researchers at a Western Australia university sent out 200 anonymous surveys to students who had been randomly selected from enrolment records. Two Australian states have decriminalized personal possession and cultivation, using a fine system, and Western Australia is considering it. Of the 55 people who sent back usable surveys, all were cannabis users. Nearly half said their personal use wouldn't increase, while 38 per cent predicted a slight increase. Eight of ten respondents said they'd grow more marijuana if the threat of jail-time was eliminated. “Subjects saw the opportunity to cultivate more of their own cannabis as a way to reduce contact with drug dealers,” noted researchers. **N.H.**

Drugs: Education, Prevention and Policy, v. 5 (1): 47-58. Sarah Maddox et al., School of Psychology, Murdoch University, Murdoch, Australia.

Book helps control bulimia

Guiding bulimic patients through a process of change with the help of a self-care manual showed similar results as standard cognitive behavioral therapy (CBT), but with significantly less therapist time, a small-scale German study found. A total of 62 patients were randomly assigned to receive a self-care manual plus eight sessions of CBT every two weeks, or to 16 sessions of weekly CBT. Midway through the study, depression was resolving faster in patients treated with CBT, while patients using guided self-change had greater knowledge gains about issues related to eating disorders. At 43 week follow-up, about 70 per cent of patients treated with guided self-care had stopped binge eating and 61 per cent had stopped vomiting, compared to 71 per cent of CBT patients in both areas. Weight increased significantly in those who had stopped binge eating and vomiting. **P.H.**

American Journal of Psychiatry, v.155(7): 947-953. Cornelia Thiels et al., Bielefeld Polytechnic, Bielefeld, Germany.

Diet for a healthy user

Few addiction programs teach a key component of recovery — healthy eating

BY PAM HARRISON

MOST OF US WOULD ASSUME THAT something as basic as nutrition would be an integral part of any treatment program.

Yet if that were the case, how to explain the battery of telephone calls, e-mails and faxes over the years to Trish Dekker, a registered dietitian at the Centre for Addiction and Mental Health's Donwood Division — all asking for advice on helping recovering alcoholics and other substance abusers get through the tough detox period and beyond.

"I've been working in addictions for over 14 years, and I was getting calls from all over the country from people who were trying to deal with somebody recovering from alcohol [among other drugs]," she says.

Struck that hardly any Canadian centres offered programs on healthy eating, Dekker drew on her experience both as a registered dietitian and as a teacher to put together a comprehensive manual to help dietitians and other professionals nudge their clients back along the road towards improved health.

On the surface, the nutritional basics it advocates read like Canada's Food Guide.

"The most critical thing I try to teach clients is that they must establish a regular meal pattern — which means that they have to eat breakfast," says Dekker. Breakfast, as the first and most important meal of the day, increases metabolism and the body, long deprived of essential nutrients, starts to use food more efficiently.

However, getting breakfast down is not that easy. "The people we see here haven't been eating, or if they do eat, they eat at the end of the day when they suddenly realize they are starving. Then they binge on anything that is fast and easy," she explains.

Arriving in withdrawal, they're usually in poor physical shape: exhausted, ill and nauseated at the thought of food. This mind set is hardly conducive to getting clients through the more introspective aspects of treatment, during which they have to address tough questions such as why they drink.

"By helping clients realize that nutrition is

part of their recovery — and a lot of them have never made the connection — we see the change that starts to happen, we see that they are able to concentrate better. When they begin to feel well, they begin to recover well," says Dekker.

Although sometimes nutritional deficiencies can have subtle effects, alcohol abusers are in danger of developing more overt physical illnesses. For instance, they are at risk of various anemias, since alcohol suppresses the bone marrow and blood cell production. Other potential conditions are polyneuropathy, a degenerative disease of the nerves; weakness and pain in the legs and feet; and chronic pancreatitis, cirrhosis and other alcohol-related diseases of the liver, notes Dr. Joe Takamine, former chairman of the

which helps to reverse muscle wasting commonly seen in alcoholics and to reduce the often-present abdominal ("Molson muscle") fat, she says.

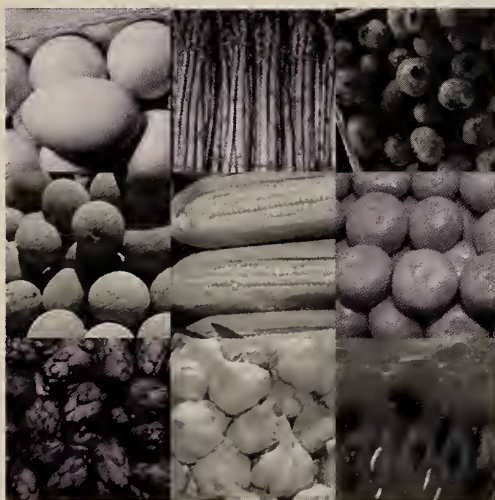
If a recovering alcoholic has overt nutritional deficiencies, Dr. Takamine prescribes a supplement specific to the underlying disorder: Vitamin B6, for example, for polyneuropathy or neuritis (nerve lesions); folic acid for those with red blood cell anemia; potassium for electrolyte disturbances. At the Centre, recovering alcoholics also get vitamin B and sometimes vitamin E to improve their immune status.

Both experts advocate a common sense approach to diet: natural foods including whole grains, fruits and vegetables, limited caffeine and soda pop. They agree that there's no need for special nutritional supplements such as Rebound, currently marketed in the U.S. for the recovering alcoholic, which cannot compensate for those who refuse to feed their body properly or continue to drink.

A regular meal pattern also helps offset cravings for sweets that start to kick in around mid-afternoon. These cravings may not be as bad as drinking, Dekker suggests. But if users substitute one unhealthy behavior for another one, their chance of developing cardiovascular disease, cancer or diabetes — already higher than normal in the alcohol-abusing population — increases again.

"The thing we have to teach is that the best healer is a rational diet, a rational amount of exercise, and time," says Dr. Takamine.

Professionals interested in the manual, *Nutrition and Recovery: A Professional Resource for Healthy Eating During Recovery from Substance Abuse*, may contact Trish Dekker at (416) 425-3939 ext. 2234. ■



American Medical Association's Task Force on Alcoholism, now in private practice in Santa Monica, CA.

The key symptom clients almost universally experience is overwhelming fatigue, which is a flag for underlying nutritional deficiencies. Users' bodies need more nutrients than normal to detoxify the chronic alcohol intake, and compensate for the lack of nutrients.

In the early stages of withdrawal, the Centre gets its residential clients to adopt a "graze-all-day approach" — "not so much to focus on meals," Dekker notes, "but to take advantage of the access they have to food and to eat little amounts throughout the day."

As clients start to feel better, they are encouraged to eat every three to four hours — a concept that amazes many people, but

Striking a balance

Advocates call for more forensic beds — but not with a loss of community care

BY TAMSEN TILLSON

THERE IS A WOMAN IN A CORRECTIONAL facility in Toronto who is not a criminal. Because she's mentally ill, experts agree she ought to be in a psychiatric hospital. "The prosecutors, the police, the doctors, we all agree that she should be in hospital," says her lawyer, Daniel Brodsky. Instead, she's in jail — in segregation to protect her from the other inmates.

Why haven't they placed her where she belongs? Quite simply, there are no forensic beds open to accept her at the moment.

This is neither a unique example nor is it a new state of affairs in the murky territory where criminal law and mental illness overlap. As many as 1,600 of the 8,000 inmates currently jailed in Ontario suffer from mental illness, according to the provincial Corrections Ministry. Some of them, like the woman above, should be in hospital instead of jail, but there's no room for them.

"I have a lot of clients who are mentally ill and improperly placed," says Brodsky. "It's a very frustrating system to work with. If you're into civil liberties, there's a lot of work to be done."

"There is certainly a lack of appropriate inpatient beds for forensic patients," agrees Dr. Howard Barbaree, clinical director of the forensic program at the Centre for Addiction and Mental Health.

All of this springs from a trend that began decades ago in North America to reduce inpatient care. Some 10,700 psychiatric beds have been closed in Ontario alone since the early 1960s. "It's partly motivated by a desire to save budget dollars," says Barbaree, "but also with advances in medical care, the need for hospital beds in mental health care has gone down."

"The problem has been that the cutbacks have gone beyond what their needs are," says

Barbaree. In addition, he says, the proportion of the savings re-invested into community care has been disappointing. Brodsky is more cynical. "Outpatient treatment in Ontario consists of this prescription — a rooming house and a television set."

The Ontario Ministry of Health is aware of the need for change. An arms-length Health Services Restructuring Commission has noted the need for more forensic beds, and this spring a health ministry analysis called for the addition of 58 forensic beds in Toronto and 49 in Hamilton.

In addition, following a report filed in June by Scarborough Centre MPP Dan Newman, based on a consultative review of mental health reform, Health Minister Elizabeth Witmer announced \$60 million for expanded mental health programs, some of which will be allocated to additional forensic beds.

While these initiatives are welcome among both the legal and mental health communities, mental health workers are less than confident that the increase will cover the demand. "It's hard to know what's enough," says Barbaree. "The numbers [found not criminally responsible because of mental disorder] in the province have been increasing by 10 per cent per year for several years."

They also worry that where the right hand giveth, the left hand taketh away. In many cases, the beds that are being added at the forensic level are being taken from the front end — from those who are mentally ill and in distress, but have not broken the law.

A new procedure in place for the past few months sends offenders directly to hospitals, which have to make space for them. "The downside is that for patients looking for psychiatric care who are not in trouble with the law, there

are no beds for them because they're taken up by offenders coming in from the jails," says Barbaree.

The government ordered a forensic psychiatric unit to be opened at the Whitby Mental Health Centre, for example, but didn't provide sufficient funds to pay for it. "The management group of the hospital had to make decisions as to how we'll meet our budget," said a source at the Health Centre who asked not to be named. The group proposed the closing of Whitby's popular STEP Program, (which stands for Skills, Training, Treatment and Education Place for the treatment of schizophrenia and other mental illnesses that cause psychosis) as well as one of three psychiatric rehabilitation wards, to make up for the shortfall. A public outcry ensued, and in response to pressure from a hastily-formed "Save STEP Committee," Witmer declared that the province would not allow STEP to close. No decision has yet been made as to how the forensic unit at Whitby will be funded.

But as more emphasis is placed on forensic care, Barbaree says, the mentally ill in the community aren't getting the services they require. "They're unable to cope with the demands that the community imposes on them, and quite often they get into trouble with the law," he says. While the offences they commit are often minor ones — such as destruction of property or petty theft — they end up in the criminal justice system, which might not have happened if they'd received adequate care earlier. And very occasionally, notes Brodsky, a mentally ill person is turned away by the medical community with tragic consequences — suicide, assault or murder.

"Yes, we would say there's a need for more money for community services, and there's a need to get those services set up before any further closures," says Ruth Stoddart, executive officer/senior co-ordinator, policy development of the Canadian Mental Health Association, Ontario Division. She is hesitant to link lack of care with crime, however, noting, "There's a thin line between the right to treatment and the right to refuse treatment and criminal acts."

Barbaree asserts that things are moving in the right direction. "There's a lot of support for the increase in community resources and I think there's good understanding of this problem at the Ministry of Health... but an understanding and dollars are two different things." ■



focus on **Concurrent Disorders**

Does harm reduction

have a place in treating concurrent disorders?

BY JULIA DRAKE

CLIENTS WHO STRUGGLE WITH THE DOUBLE WHAMMY of addictions and mental health problems often face a treatment quandary.

That quandary lies in the fact that some mental health treatment programs reject clients who use alcohol or illicit drugs. At the same time, some addictions programs demand that clients be off all medication, including psychiatric medication, before receiving inpatient treatment.

Problems in treating concurrent disorders exist in many countries, says Peter Phillips, a clinical nurse specialist at the East London Drug Dependence Unit of the Tower Hamlets Healthcare NHS Trust. Because it is still a relatively new concept in the U.K., for example, appropriate services and protocols have yet to be established, he said at the Ninth International Conference on the Reduction of Drug-Related Harm, in Sao Paulo, Brazil.

A further complication is that both sets of services often reject the client with concurrent disorders on the grounds that the other disorder is primary.

Canada, it seems, is no exception. Some of Ontario's psychiatric hospitals have exclusionary admission criteria requiring that patients not be intoxicated. Some addictions and mental health services are essentially ill-equipped to handle people with concurrent disorders.

These clients do tend to get bounced around between services, says Steve Lurie, a member of a task force launched by the Canadian Mental Health Association (CMHA), Ontario Division.

With such problems in getting treatment, what's a person with concurrent disorders to do?

Phillips believes that harm reduction should take a more prominent role in treating people with concurrent disorders. Harm reduction is an approach that seeks to minimize the harms caused by drug use first, rather than requiring clients to stop their use immediately. He says Britain's focus on abstinence leads to high drop-out rates for these clients.

In its 1997 policy paper on concurrent disorders, the CMHA task force also supports a greater role for harm reduction in treating concurrent disorders. But the reality is that harm reduction — whether it's called harm minimization or merely a more flexible approach — is already at work in many programs in Canada.

At Calgary Foothills Hospital, for example, abstinence is not a requirement for admission to treatment, says Nady el-Guebaly, director of the Addictions Centre and president-elect of the Canadian Psychiatric Association. When working with people whose psychosocial skills have been affected by mental illness, insisting on abstinence means "you'll never see them again," he says.

"There are programs and services that are sensitive to these issues,"

says Lurie, who's also executive director of CMHA's Toronto Branch. "Some joint programs are in place, and new ones are starting up, but we need to find ways of making that happen more often."

The CMHA task force advocates for a more collaborative effort — a co-ordinated system that provides better care to clients.

Any collaboration needs to be "based on mutual respect for different treatment cultures," says el-Guebaly.

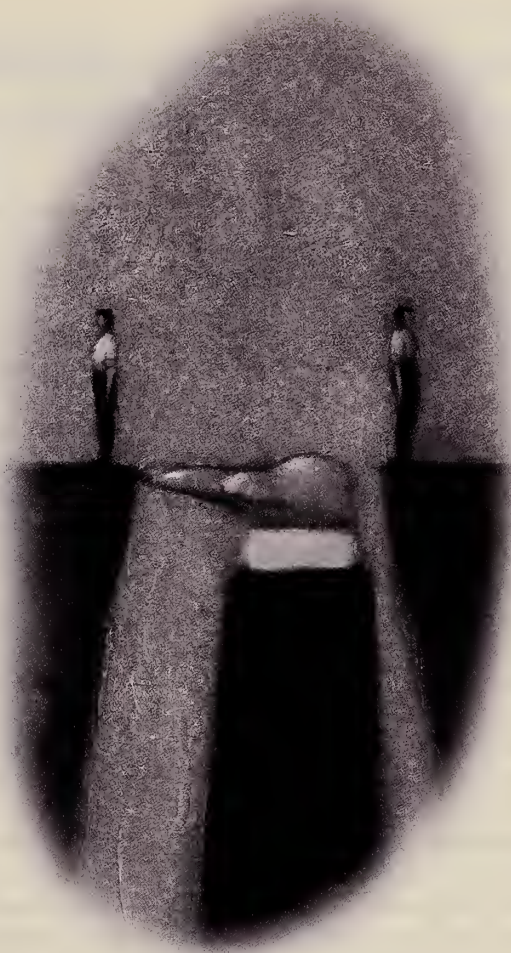
Lurie cites the Assertive Community Treatment Program in Scarborough, Ont., as an example of merged addictions and mental health expertise. The program has hired an addictions specialist to better serve clients with mental health problems.

Ontario's Centre for Addiction and Mental Health has launched a concurrent disorders treatment program in Toronto that will help share information with facilities across the province. The centre is also launching a collaborative models project in sites around the province, which will involve working with community agencies to review the best approaches for helping these clients.

Phillips supports a move towards a collaborative, all-encompassing, approach. Since the issues involved are not solely medical, psychiatric or psychological they necessitate effective working relationships between the full range of community agencies, such as housing departments, legal services, welfare services, leisure facilities, criminal justice and medicine, says Phillips.

The CMHA recommends that policy-makers, planners, researchers and service providers include the range of philosophies, service orientations and models of traditional or alternative treatments and supports that recognize individual capacity for change, wellness and recovery.

"No single treatment modality works for everyone," says Lurie. "The trick is finding the approach that works best for the individual client." ■



Combined programs address multiple needs

AS AN ALCOHOLIC WHO HAS BEEN DIAGNOSED WITH rapid-cycle bipolar disorder, Larry considers himself something of an expert in the treatment of substance abuse and the treatment of mental health problems.

Mostly, Larry has found that specialists tend to focus on one problem or the other. "Places where they treat for alcoholism, they don't key into the mental health issues. Places where I've had treatment for mental health issues, haven't keyed into the substance use issues," Larry says.

During treatment for alcoholism, he was surprised at the number of people who told him that if he just stopped drinking, his devastating mood swings would disappear. He was equally amazed that his drinking was largely ignored while he was a resident in a psychiatric hospital. "It beats me that they didn't know," he says looking back.

Yet, for Larry, there was no neat dividing line between his drinking and his illness and no way to separate the two. In February, he entered St. Thomas Psychiatric Hospital for a 26-day residential treatment in a program designed to address concurrent disorders — mental health problems coupled with substance abuse, followed by a month "tune-up" in July. He says that he has now experienced his longest period of sobriety and mental stability since 1992.

The program at St. Thomas was created, says nurse-manager Christine Wadlugh, because clients who need medications to control symptoms of depression, bipolar disorder or schizophrenia, were sometimes excluded from regular treatment programs. While clients must be stabilized to enter the program, their need for medication is accepted as a fact of life. Medical professionals adjust medications and can observe for signs and symptoms of complications. As well as mental health clients, the St. Thomas program includes a small component of HIV/AIDS clients. The mixture works, Wadlugh says, because the treatment program, which is cognitively-based, is very individualized.

Other programs also reflect a trend to gear treatment to the multiple needs of the client with a concurrent disorder. In Kingston, Don Cowell,

director of Options for Change, a community-based drug treatment centre, co-leads a weekly client meeting with staff from Friendship Homes, an agency that provides support services for people with mental health problems.

The meeting offers Friendship Home clients a way to address substance abuse in an environment that is both familiar and supportive. The groups are kept at four to eight participants because large numbers can be intimidating, Cowell says. The two-hour meeting is shorter and less intense than many addiction groups because some participants do not have the focus to tolerate longer sessions. For someone who can't stay still very long, some treatment programs are too demanding in terms of time and focus.

In downtown Toronto, CONTACT is an outreach program based at St. Michael's Hospital. CONTACT's multi-disciplinary team, including psychiatrists, an occupational therapist and an addictions counsellor, uses an Assertive Community Treatment (ACT) model. The approach is to build rapport gradually with the client. "If a homeless person uses crack cocaine and has schizophrenia, we try to engage them in whatever way they wish to be engaged," says co-ordinator Margaret Gehrs. The team deals with a range of issues, including housing and finances.

CONTACT clients might be considered amongst the most challenging. They have complex problems and severe mental disorders. Half are homeless. A high proportion abuse substances.

Some clients have fallen through the cracks in regular treatment programs. Others are referred, as a last resort, to CONTACT. While Gehrs admits there are no guarantees, they have found that improved social stability and a less chaotic lifestyle can bring a significant reduction in substance use.

Even with low levels of substance use, the interactions with medications can play havoc with the lives of people with concurrent disorders. "We can see pretty low levels of dependency, but the consequences can be serious and severe," says Cowell, "Our job is to help eliminate or reduce the effects of the problematic substances, and enhance their mental health." **PENNY STUART**

Finding psychiatric disorders in addicted clients

Despite the high probability that an addiction client might have other psychiatric disorders, there is no widely-used standard to assess whether a client does indeed have a concurrent problem.

Several brief screening assessments do exist, which could alert clinicians to their clients' need for a full psychiatric evaluation. But most screens available have some flaw or other: some yield results that are too general or inaccurate, while others are complex to administer or are out-of-date.

A new tool currently in development, the Psychiatric Screener, aims to deal with these issues. Based on the DSM-IV and International Classification of Diseases, its computer format enables clients to quickly respond to questions about their mental state and substance use, with as much or as little therapist supervision as they require.

"We want to identify people who need psychiatric treatment. People whose problems are unattended will have poor results in treatment," says Dr. Juan Negrete, a psychiatrist who led the development of the Psychiatric

Screener at the Centre for Addiction and Mental Health.

The screener can be used in all types of clinical facilities to identify clients with current mental health problems who need a full psychiatric examination, he adds. Counsellors can choose whether clients need to complete the entire screen, or whether it should focus on particular disorders.

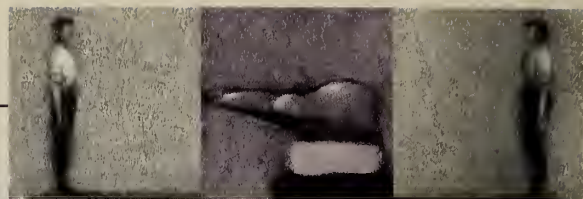
A field test with 466 people at the general intake of an addiction treatment program found that about 34 per cent met referral criteria for different disorders, the most common of which was depression.

"We've had a lot of positive feedback from clients," says Jane Collins, a consultant to the project. "Many addiction clients were never diagnosed before, but always felt there was something wrong with their lives."

Developers worked to avoid the drawbacks associated with other well-known screens. For instance, the SCID-Screen-Patient Questionnaire (a short version of the Structured Clinical Interview, Diagnostic) explores symptoms, but doesn't ask enough detail to pinpoint an actual disorder.

Another screen, the PRIME-MD, yields more specific results, but identifies fewer disorders, and its computer version is not as easy to complete.

Dr. Negrete, Collins and their colleagues are now beginning scientific tests on the validity of the Psychiatric Screener. Once the research is complete, likely next spring, they hope to disseminate it more widely. **ANITA DUBEY**



Separate treatments ineffective expert says

THE TRADITIONAL METHOD OF TREATING SEVERE MENTAL illness and substance abuse as separate, mutually exclusive conditions is ineffective, says Dr. Kim T. Mueser of the New Hampshire-Dartmouth Psychiatric Research Centre.

Instead, patients with concurrent disorders should receive integrated treatment by the same clinicians, he told participants at the Penetanguishene Substance Use, Aggression and Mental Disorder conference in June.

According to the Addiction Severity Index, more than 50 per cent of individuals with a severe mental illness also suffer from substance use disorder, compared to just 16 per cent of the general population, said Dr. Mueser. He added the rate of recovery for concurrent disorders is quite low. "By most estimates between three to five per cent of individuals per year achieve stable abstinence, and this forms part of the motivation for intervention in this group."

When individuals are fortunate enough to receive treatment for both disorders, they are handled either sequentially or parallel to each other.

If the two programs occur at the same time but separately, they can be incompatible, he said, citing the example of traditional confrontational tough love approach of most 12-step programs.

"You may confront someone in a group context and say 'you're lying to us, to your family and to yourself and you have been your whole life' — that is the kind of straightforward confrontation strategy that is supposed help a person own up to having a substance use disorder," he said.

But "people with severe mental illness tend to be very sensitive to this kind of interpersonal censure. Their capacity for denial is also much greater than the primary substance abuse population. They can

deny basic reality as we think of it, so denying they have a substance use disorder should be no problem," and will result in the patient dropping out of the program altogether.

Treating both disorders sequentially also "tends to be very ineffective because it doesn't address the interactions between the disorders." For example, during the manic phase for people with bipolar disorder, "individuals will do more of everything including drugs or alcohol, so trying to address the substance abuse without addressing the mania doesn't do much good either."

Dr. Mueser says his centre has conducted two studies which indicate that integrated treatment for concurrent disorders is the more effective method of treatment.

"We define a program as an integrated program if the same clinicians are treating both the mental illness and substance disorder at the same time, and the interventions appear seamless, and there is continuous responsibility assumed by the treatment provider."

He said the goal of an integrated concurrent disorder program has to be more than the reduction or elimination of substance abuse "because it interacts with a range of other spheres of functioning, and effective programs need to address other aspects of day-to-day living."

This means case-management teams must be multi-disciplinary, flexible and assertive with a strong outreach approach. "Our research shows fairly constant rates of improvement, especially after the first year of treatment and over many subsequent years," he said.

Finally, the treatments must be long-term and incorporate shared decision-making with both families and the patients themselves, he said. **KALYANI VITTALA**

Consumer Voices:

Kathy's Story

I WAS DIAGNOSED WITH SCHIZOPHRENIA WHEN I WAS 25.

That was about 30 years ago. After that, I was in the hospital for four years off and on, because my husband didn't like me taking medications.

For a while after that I lived in Puerto Rico, which helped a lot. For many years I was functioning on medications.

My first career was as a model and dancer, and I taught ballet. Later, I went to nursing college and graduated at the top of my class. I worked as a nurse at several different hospitals over the years. Fifteen years ago, I also worked in the admitting department of a psychiatric hospital. I took good care of my patients and helped them as much as possible.

I only started drinking when I was about 40, after reaching menopause. I had fits of depression. But I did not take hormones or have hot flashes.

I guess you could call me a closet drinker since I drink on my own. Most of my friends also don't know I was in the hospital.

About eight or 10 years ago I had a breakdown, and the system told me I was too sick to work. My disability papers were signed and I couldn't work anymore. After I gave in to the system, I became depressed. I had another breakdown two years ago, and then again this past summer.

I attended an alcohol treatment program eight years ago, and did quit drinking for about a year and a half. But then I started again and have been in treatment this time for about two years.

I attended a post-traumatic stress group for my drinking a little while ago. That's where I realized that my childhood was not happy. I had blocked that, thinking I had a happy childhood. I was an illegitimate child and my mother never wanted me, so I lived with grandparents.

Realizing this made me drink even more. My therapist is very patient with me. I don't know why. But I'm working through it now. There's a lifetime of blocking this information, and it's all coming out now because of my treatment for drinking.

My theory is that the condition of "schizophrenia" is self-inflicted, based on the stress and pain of childhood. I know there's hereditary genes, but I think it's like cancer where some people get it and others don't. I think every person with schizophrenia should attend therapy for post-traumatic stress syndrome. I also think that groups should include people who are healthy, to act as role models.

It's difficult for me to deal with all this about my childhood now. I feel sorry for myself. But I have hobbies that keep me busy. I have an exercise machine and am starting to take glass painting.

Q & A

Answers to common questions on concurrent disorders

What is a concurrent disorder? A concurrent disorder describes a condition in which a person has both a mental illness and a substance use problem. Another term is comorbidity, and in the United States, the expressions dual diagnosis, dual disorder, or mentally ill chemical abuser are used.

A concurrent disorder is a general term referring to a broad range of mental illnesses and addictions a person could have. For example, someone with schizophrenia who abuses cannabis has a concurrent disorder, but so does a person with alcoholism and clinical depression. Treatment approaches for each case could be quite different, however.

Is it more likely that a mental disorder leads to substance abuse, or the other way around? It depends on the person. In some cases, the heavy use of alcohol or other drugs can result in depression, other symptoms of mental conditions, or in extreme cases, substance-related brain damage. Sometimes alcohol or other drugs are used to alleviate distress related to a mental health problem.

What is the best way to treat concurrent disorders? The approach that seems most promising in studies and makes the most sense is to integrate treatment for both conditions together. Another approach is to treat one issue first and the other one afterwards. A third model is to treat both conditions at the same time, but independently.

Initial research suggests that integrated treatment is probably the best approach, because it customizes treatment and considers a person's full range of problems, not only those important to one treatment area.

Are integrated services widely available?

Not yet, but it doesn't mean service providers working in either the addiction or mental health fields can't find ways to help their clients with concurrent disorders.

One way is by learning to recognize and understand the most common concurrent disorders. Studies suggest that people with anxiety, mood, and anti-social and borderline personality disorders, as well as schizophrenia, may be at a higher risk of having a substance problem. If mental health or addictions professionals are able to recognize the concurrent disorder, they can direct their clients to more specialized help.

How can concurrent disorders be detected? Experts advise routine screening for concurrent disorders in all treatment programs. A mental health professional, therefore, should be asking questions about substance use, and using brief screening tools such as the CAGE or MAST. An addiction professional could also use instruments such as the Beck Depression and Anxiety Inventories or Dissociative Experiences Scale. These are less helpful because they do not make the difference between substance "induced" distress and the true psychiatric disorder. Nonetheless, psychological distress ratings help identify individuals who require a fuller psychiatric assessment.

Therapists should also be sure to ask about housing, budgeting, legal and other life problems among those with concurrent disorders, since this group is particularly vulnerable in these areas.

How well are concurrent disorders being treated overall? A 1996 Ontario study called "Travelling the Same Road: A Report on Concurrent Disorders in Ontario" asked mental health and addictions agencies how they dealt with concurrent disorders.

Most said they relied on the individual to report the problems, while about half had a clinical assessment or physician evaluation. Only four per cent used a special assessment for concurrent disorders.

Once they made a diagnosis, almost 90 per cent of centres said they referred their clients to other agencies. However, they cited problems with referrals, in that clients dropped out of the referral program, services were not tailored to client needs, or the client didn't follow through. Other barriers in making referrals were the lack of services and long waiting lists.

More than 400 mental health, addictions agencies, psychiatric hospitals and hostels responded to this survey.

Aren't there philosophical differences in treatment for addictions and mental health problems? There is recognition that a philosophical rift between addiction and mental health field affects treatment delivery, according to a 1996 Health Canada document, "Exploring the Links between Substance Use and Mental Health."

For instance, some addictions professionals or 12-step groups may be wary of people taking required medications for their mental health condition, since they are psychotropic drugs. Another example is that some mental

health programs require abstinence from people seeking help, and do not recognize that relapse is common in the process of recovery. The Health Canada document notes that "...despite good intentions, service providers tend to impose their ideas and do not respect the role that substance use can play as a coping strategy for people with [concurrent] disorders."

Can these differences be resolved? Over the past few years, clinicians, researchers and policymakers have started to think about how to treat people with concurrent disorders in a co-ordinated way. Professionals are starting to educate themselves. Ultimately, this is improving services.

How many people have concurrent disorders? This is a difficult question to answer, because the studies that exist look at different populations and use different screening tools.

Overall, it is safe to say that people in treatment for either an addiction or mental health disorder have higher rates of concurrent disorders than the general population.

In one large U.S. study, about a third of people with a mental or alcohol disorder had a concurrent disorder. Half of the people with other drug problems had a mental disorder.

A smaller study in Edmonton, Alberta showed similar results. Almost a third of mentally ill individuals had a substance use problem, and the same fraction of people with alcohol abuse or dependence had a psychiatric diagnosis. Among illicit drug users, almost half had a mental illness.

Do any centres specialize in treating concurrent disorders? Some centres do have programs. The article on page 13 has just a few examples. ■

References:

- Dual Diagnosis of Major Mental Illness and Substance Abuse*, vol. 2. Recent Research and Clinical Implications, Concurrent Disorders, Policy Consultation Document - Canadian Mental Health Association, *Travelling the Same Road: A Report on Concurrent Disorders in Ontario* - Centre for Addiction and Mental Health, *Exploring the Links Between Substance Use and Mental Health* - Health Canada, *Comorbidity of mental disorders with substance misuse* - *British Journal of Psychiatry*, vol. 171: 4-5, *Dual Disorders: Essentials for Assessment and Treatment*, *Co-occurring Mental Disorders and Addictions: Scientific Evidence on Epidemiology and Treatment Outcomes* - Centre for Addiction and Mental Health

Obsessive-Compulsive Disorder: Theory, Research and Treatment

eds. Richard P. Swinson et al., Guilford Press, New York, 1998. An impressive panel of researchers contributes the latest information on obsessive-compulsive disorder in this comprehensive resource. Chapters cover everything from diagnostic issues and the range of treatments to family issues and genetics. An appendix lists other resources, including organizations in North America, France, U.K., Australia and South Africa, as well recent books and Internet sites.

Into the Daylight: A Wholistic Approach to Healing

Calvin Morrisseau, University of Toronto Press, Toronto, 1998. Anishnabe author Calvin Morrisseau advocates a way of healing that considers the importance of aboriginal elders and traditional healing methods. In describing a model for recovery within the structure of family and community, he delves into painful stories from his own childhood — parents who spent weekends drinking, sexual abuse, the fiery death of his best friends — and his subsequent alcohol abuse and recovery. Morrisseau is program manager at Wee-chi-it-te-win Child and Family Services in Fort Frances, Ont.

Childhood Abuse and Chronic Pain - A Curious Relationship?

Ranjan Roy, University of Toronto Press, Toronto, 1998. Increasing evidence points to the effects of childhood abuse on chronic pain. This volume, written by a social work professor in clinical health psychology at the University of Manitoba, includes case studies as well as a review of research-based treatment studies. It examines the effect of different types of abuse — neglect, sexual and physical abuse — on pain.

The primal roots of addiction

In the prologue to *Wild Hunger: The Primal Roots of Modern Addiction*, Rutgers philosophy professor Bruce Wilshire describes the "intensely — strangely — awake" feeling he experienced while watching a falcon — an inert pigeon clasped in its talons, a small bloody feather glued to its beak, its eye shining like "living glass."

His visceral reaction to the scene, glimpsed from an upstairs window in his New Jersey home, underscored his belief that, most of the time, most of us exist in a state of semisomnambulism. Yet we yearn for primal excitement, despite the overlayings of agricultural, then industrial and now electronic life.

Addictions, says Wilshire, are a search for that lost connection.

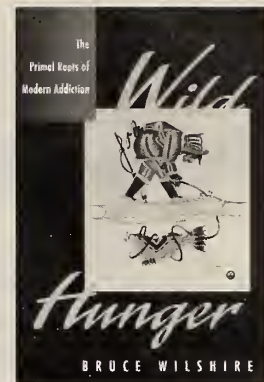
"I think that addictions stem from breaking the participatory bond our species has had with [the] regenerative source, with wild Nature over the ages — kinship with plants and animals, with rocks, trees and horizons," he writes. "Even terror is a bond with what terrifies. In such moments we are 'out of ourselves,' ecstatic, spontaneous, full of the swelling presences of things. Addictions try to fill the emptiness left by the loss of ecstatic kinship... [They are] slavishly repeated attempts to keep the emptiness at bay."

Getting in touch with one's roots is a popular topic these days. Such books as Pincola Estes' *Women Who Run With the*

Wolves and Thomas Moore's *Care of the Soul* topped the bestseller lists. And *Wild Hunger* is every bit as literate and spiritually refreshing. Wilshire speaks to Everyman (and woman). Be it drugs, cigarettes, obsessive shopping, working or gambling, compulsive talking, or systematic eating and disgorging — the author likens them to ascetics' orgiastic mutilations of the flesh — there are few who won't find a resonating chord. Obviously poets and philosophers have longed for the lost connection; Wilshire quotes everyone from Homer (the inspiration for the book's title) to Byron and the Bible.

To satisfy the primal wild hunger and banish addictive behavior, the author offers regenerative rituals that involve myths, ceremonies and the arts, particularly painting and music. But this is not a "how to" book of clearly defined steps. Rather, it relies on allegory, story-telling and musings about the nature of Nature to extend the message that life is at its best without any crutches. **BARBARA FULTON**

Wild Hunger: The Primal Roots of Modern Addiction, Bruce Wilshire, Rowman & Littlefield, Lanham, Maryland, 1998, 287pp, US\$24.95



Defeating depression

The tragic story of a university student shows how insidious the course of depression can be — and how it can easily go unrecognized by those who should be able to identify it.

The student's physician father, who had been treated for depression himself, had been worried about his son and arranged for him to see a psychiatrist. But the son refused further help, and after moving in with friends several months later, appeared fine at weekly visits home. Eventually, a call from a concerned roommate alerted the parents that something was amiss. The son refused their help again. Two weeks later, he committed suicide. Afterwards, they learned he had practically confined himself to his bedroom over the past months.

The authors of *Defeating Depression* hope to help people with depression, along with their families and physicians, recognize and understand their condition. This slim, colorful volume — more or less a "pocket guide" to depression — begins with a brief but informative overview of different types of depression.

Its three key authors, all psychiatry professors at the University of Toronto with two on staff at the Centre for Addiction and Mental Health, note that family physicians see at least one person with significant depression each day, who

will likely appear complaining of diverse physical problems.

And this is part of the reason they wrote this book — non-detection is one of the first barriers a person with depression faces.

The authors advise that a proper diagnosis should be carried out by a physician and psychiatrist, particularly since depression overlaps with conditions such as anxiety disorders. But they include several short screening tools to identify depression, anxiety and stressful life events, which is perhaps a less threatening way for a person to take the first step in recognizing their condition.

They review both current psychological approaches and antidepressants in use — along with pitfalls and side effects — but suggest that a combination of treatments works best.

While acknowledging that some chapters in the book may be more useful to physicians than patients, and vice versa, ultimately, they hope the book will empower people with depression. "Very often," the authors write, "a patient who has read a book such as this is able to help the doctor choose the most appropriate treatment."

Defeating Depression, Sidney H. Kennedy, Sagar V. Parikh, Colin M. Shapiro, Joli Joco Publications Inc, Thornhill, Ontario, 1998, 87 pp., CDN \$19.95

The Last Word

The politics of **pot**

The move to decriminalize makes for **strange political bedfellows**


BY WAYNE HOWELL

THE POLITICS OF POT IS MAKING FOR SOME STRANGE political bedfellows. The movement to legalize — or at least decriminalize — marijuana has been traditionally rooted in the political left. Indeed, it often appears to be led by aging hippies. But there are a surprising number of those on the political right who wish to decriminalize marijuana, if not all so-called recreational drugs.

The financing behind many American decriminalization initiatives comes from George Soros, a right-wing billionaire financier. American conservative William F. Buckley has called for the legalization of marijuana in his influential *National Review*. Ted Byfield's conservative *Alberta Report*, the closest thing Canadians have to *National Review*, came out with a decrim-sympathetic feature article in August 1997, around the time the trial of Chris Clay (a cannabis activist who sold marijuana plants at his Hemp Nation store) was making headlines. Even the Fraser Institute, a Canadian think-tank widely known for its conservative if not downright reactionary bent, sponsored a symposium to explore the merits of legalization, decriminalization and harm reduction. It was the right-wing Freedom Party that contributed to Chris Clay's legal expenses. And when a private member's bill to investigate the possibility of legalizing medical marijuana was introduced in the House of Commons, it wasn't from the N.D.P. — it was from a member of the Reform party, a party traditionally associated with a "lock 'em up" rather than a "light 'em up" policy.

The left and right come at the drug problem from different angles. The left sees the expensive War on Drugs, with its prohibitions, fines and jail sentences as a social problem that should be solved by shifting the social spending from the law enforcement field to the medical field. The left doesn't have a problem with throwing major public money at the drug problem, it just thinks the money is currently being thrown in the wrong direction. And while the left does tend to see a decriminalized world through rose-tinted "peace and love" glasses, it realizes that government has a role to play in any distribution system, a role similar to one it currently plays in the distribution of alcohol and tobacco.

The right wing, on the other hand, wants to decriminalize drugs for ideological reasons. Most decrim activists on the right are of the 'libertarian' persuasion, people who mistrust all paternalistic attempts by government to control its citizens' behavior. Libertarians feel a citizen has the right to go to hell in a handbasket if he chooses, as long as he pays for the handbasket. They believe in the Rand formula. The Ayn Rand formula, that is.

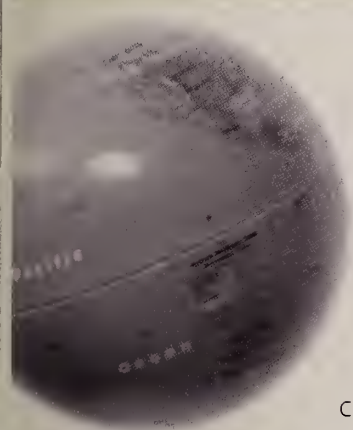


Neither side really trusts the other sides' motives. The right sees the left wing's fervent advocacy of medical marijuana use as a Trojan horse designed to carry us on a magical mystery tour back to the 1960s. It doesn't take much to make right wingers paranoid — witness their ongoing suspicion that most journalists are out to make them look like political troglodytes — so when you suspect your ally in the decrim movement is not only a fuzzy-minded "chicken in every pot" free-spending socialist, but also a "pot in every chick" refugee from some long ago Summer of Love, it is easy to be suspicious of his motives. And of course it doesn't help that left-wing activists play to the right's fears with goofy P.R. stunts, such as Chris Clay's sale of \$25 Victory Bonds redeemable for a quarter ounce of marijuana once it is legalized.

It doesn't take much to make a left winger paranoid either — witness the current fear of a libertarian agenda which, if taken to an extreme, would (a) allow anyone to have whatever drug he or she wanted with no state regulation or control and (b) provide no social support services by way of state-supported detox centres, needle exchanges or drug rehabilitation programs to deal with the fall-out from such a free-access policy. The left sees the right wing's somewhat belated advocacy of decriminalization as *its* Trojan horse designed to carry us into a brave new world of social Darwinism, in which the strong will survive (by being righteously drug-free) and the weak will be culled from the gene pool, like so many overdosing Vancouver heroin users.

When it comes to the Cannabis Nation, it appears things are not really all that different than the Canadian Nation itself: to quote Lord Durham, we find "two nations warring in the bosom of a single state." If there is any common ground between the left wing and the right wing it is that both are pragmatically opposed to a War On Drugs that (a) wastes a lot of money (b) wastes a lot of human resources, and (c) doesn't work anyway. And that, believe it or not, is something even the political centre is starting to agree on. ■

Conferences



Alberta. Contact: AADAC,
tel (403) 422-7717;
fax (403) 427-2352;
e-mail <gamblinconf
@AADAC.gov.ab.ca>.

The Face of Alcohol and Violence: From Prevention to Treatment

Oct. 6-7, Toronto, Ontario.

Contact: Education and
Training, Centre for Addiction
and Mental Health, 33 Russell
St., Toronto, ON M5S 2S1, tel
(416) 595-6020.

Addictions and the Community

Oct. 16-19, Sidney, British
Columbia. Contact: CSAM
Secretariat, P.O. Box 1873,
Kingston, ON, K7L 5J7, tel
(613) 541-3951, fax (613)
541-0175, e-mail
<csam@kingston.net>,
internet<csam.kingston.net/
annual/annual.html>.

Treating Victims of Compulsive Gambling, phases I & II

October 18-23, Orillia,
Ontario. Contact: Georgian
College, 825 Memorial Ave.,
Orillia, ON L3V 6S2,
tel (705) 325-2705, ext. 3368,
fax (705) 325-2208.

American Neurological Association Annual Meeting

Oct. 18-22, Montreal, Quebec.
Contact: Christine Sadler,
American Neurological Associ-
ation, (612) 545-6284.

XXVIe colloque de l'Association des inter- venants en toxicomanie (AITQ)

25 au 28 octobre, Sainte-Foy,
Québec.

7th Annual David Berman Memorial Dual Disorder Conference

Oct. 29-30, Vancouver, British
Columbia. Contact: Dual
Diagnosis Program, Laurel
Lafaut, #1 - 520 Powell Street,
Vancouver, BC V6A 1G9,
tel (604) 255-9843.

49th Annual Ontario Public Health Association Conference

Nov. 2-4, Barrie, Ontario.
Contact: Heather Edgar,
Simcoe County District Health
Unit, 15 Sperling Dr., Barrie,
ON, L4M 6K9,

tel (705) 721-7330 ext. 248,
or the OPHA
at (416) 367-3313.

The Long Shadows of Trauma: Traumatized Parents & Infants

Nov. 12-15, Toronto, Ontario.
Contact: Hincks Dellcrest
Institute, (416) 972-1935
ext 3345/3341,
fax (416) 924-9808,
e-mail <enerlich@cmhincks.on.ca
or hincks@interlog.com>.

Fetal Alcohol Syndrome/Neonatal Abstinence Syndrome Conference: Finding Common Ground: Working Together for the Future

Nov. 19-21, Vancouver, British
Columbia. Contact: FAS/NAS
Conference, Continuing
Education in the Health
Sciences UBC, Room 105 -
2194 Health Science Mall,
Vancouver, BC, V6T 1Z3
tel (604) 822-5398,
fax: (604) 822-4835,
e-mail <pat@cehs.ubc.ca>.

9th Annual Clinical Symposium: Overcoming Barriers in Managing Schizophrenia - Practical Approaches

Dec. 4, Toronto, Ontario.
Contact: Centre for Addiction
and Mental Health, 1001
Queen St. West, Toronto, ON,
fax (416) 535-7199, e-mail
<Ward.Judy@rit.on.ca>.

UNITED STATES

National Nurses Society on Addictions Annual Educational Conference: New Horizons on Addictions

Sept. 16-19, Colorado Springs,
Colorado. Contact: National

Nurses Society on Addictions,
4101 Lake Boone Trail, Suite
201, Raleigh, NC,
tel (919) 783-5871;
fax (919) 787-4916.

Association of Child and Adolescent Psychiatric Nurses 27th National Conference

Sept. 17-20, Atlanta, Georgia.
Contact: Association of Child
and Adolescent Psychiatric
Nurses, National Office,
1-800-826-2950.

American Methadone Treatment Association Conference

Sept. 27-29, New York, New
York. Contact: Michael
McAllister, 50-B Cooper
Square, New York, NY 10003,
tel (212) 677-3400,
fax (212) 979-1359.

Women Healing: Redefining Strength and Courage

Oct. 2-3, New York, New York.
Contact: Hazelden Institute
and Betty Ford Centre, c/o
Barbara Weiner, P.O. Box 11,
Center City, MN 55012,
(612) 213-4093, e-mail:
<bweiner@hazelden.org>

Second National Harm Reduction Conference

Oct. 7-10, Cleveland, Ohio.
Contact: Harm Reduction
Coalition c/o JPD Communi-
cations, 2712 Ninth Street,
Berkeley, CA 94710-2606,
tel (510) 843-8048,
fax (510) 843-8050.

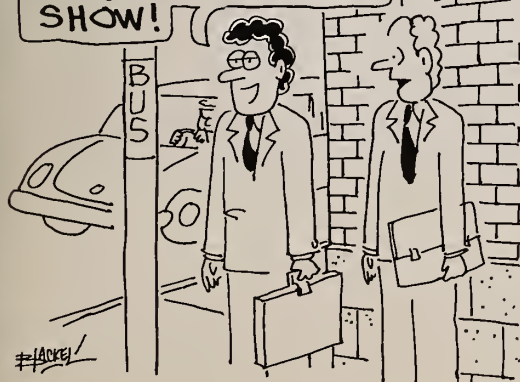
National Association of Social Work Annual Meeting

Oct. 8-9, Sacramento,
California. Contact:
National Association of
Social Work,
tel (916) 263-1153.

I WAS FEELING VERY DEPRESSED
ABOUT MY MARRIAGE AND MY
WORK SO I GOT PROFESSIONAL
HELP!

OH, GOOD! WAS IT A
COMMUNITY SUPPORT
PROGRAM?

NO... I WENT ON
THE JERRY SPRINGER
SHOW!



Miles to Go, Promises to Keep in the New Millennium

Oct. 10-13, Chicago, Illinois.
Contact: National Black Child Development Institute, 1023 15th Street, NW, Suite 600, Washington, DC 20005, (202) 234-1738.

12th Annual National Meeting on Alcohol, Other Drug & Violence Prevention in Higher Education

Oct. 15-18, Washington, DC.
Contact: Higher Education Centre for Alcohol and Other Drug Prevention, 1998 National Meeting information, 55 Chapel St., Newton, MA 02158-0160, 1-800-676-1730, fax (619) 551-2948, e-mail <HigherEdCtr@edc.org>, internet <www.edc.org/hec/natl/1998>.

Advancing the National Strategy for Suicide Prevention

Oct. 15-18, Reno, Nevada.
Contact: Anita Teague, Suicide Prevention Advocacy Network, tel (770) 488-1530.

Advancing from the Ventral Striatum to The Extended Amygdala: Implications for Neuropsychiatry & Drug Abuse

Oct. 18-21, Charlottesville, Virginia. Contact: National Institute of Mental Health and New York Academy of Sciences, c/o Israel Lederhendler, tel (301) 443-1576.

Coming Together: The First World Conference on Mental Health and Deafness

Oct. 22-24, Washington DC.
Contact: (803) 798-6767 or (803) 798-6761 (TTY).

American Academy of Child & Adolescent Psychiatry (AACAP): 45th Annual Meeting

Oct. 27-29, Anaheim, Califor-

nia. Contact: Charmaine Smiklo, (202) 966-7300.

United States Conference on AIDS

Oct. 29-Nov. 1, Dallas, Texas.
Contact: National Minority AIDS Council, Conference Registrar, 1831 13th Street, N.W., Washington, DC 20009-4432, tel (202) 483-6622 ext. 317, e-mail <llwilliam@nmac.org>.

Association for Medical Education and Research in Substance Abuse [AMERSA] — 22nd Annual Conference

Nov. 5-7, Washington DC.
Contact: Doreen MacLane-Baeder, Brown University, Centre for Alcohol and Addiction Studies, Box G-BH, Providence, RI 02912-9107, tel (401) 785-8263, fax (401) 444-1850, e-mail <AMERSA@caas.caas.biomed.brown.edu>.

11th National Conference on Nicotine Dependence

Nov. 5-8, Marina Del Ray, California. Contact: American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Arcade Level, Chevy Chase, MD, 20815, tel (301) 656-3920.

12th National Conference on Child Abuse and Neglect

Nov. 16-21, Cincinnati, Ohio.

Contact: NCCAN, 8484 Georgia Avenue, Suite 1000, Silver Spring, MD 20910-5604, tel (301) 589-8242, fax (301) 589-8246.

Consensus Development Conference on Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder

Nov. 16 — Bethesda, MD.
Contact: National Institutes of Health

American Art Therapy Association's 29th Annual Meeting: Power and Integrity in Art Therapy: A Symbolic Exchange

Nov. 18-22, Portland, Oregon.
Contact: Denny Geller, tel (847) 949-6064.

11th Annual U.S. Psychiatric Congress

Nov. 19-22, San Francisco, California. Contact: Continuing Med Education, Inc., Meeting Information, tel (714) 250-1008.

Prevention Think Tank Symposium

Jan. 21-24, 1999, Singers Island, Florida.
Contact: Prevention Think Tank, Barbara Jacobi, P.O. Box 5941, Bethesda, MD 20824, tel (301) 518-2354, e-mail <bajacobi@erols.com>.

internet <www.jacobi-assoc.com/prevthink/symplosion.html>.

Self-directed Internet Courses

Contact: Florida School of Addictions Continuing Studies, Inc. P.O. Box 13089, Tallahassee, Florida 32317; web <www.addictions-ed.com>; tel 1-800-530-3134.

ABROAD

Addictions '98: An International Symposium on Comorbidity Across the Addictions

Sept. 25-27, Newcastle upon Tyne, United Kingdom.
Contact: Amy Richardson, Addictions '98, Elsevier Science Ltd., The Boulevard, Langford Lane, Kidlington, Oxford OX5 1GB, tel 44 1865 843 643; fax 44 1865 843 958; e-mail <a.richardson@elsevier.co.uk>.

Ninth Annual Conference on Drug Use and Drug Policy

Oct. 1-3, Palma de Mallorca, Spain. Contact: Department of Educational Sciences of the University of the Balearic Islands. Dr. Carmen Orte Socías or Prof. Martí X. March Cerdà, Carretera de Valldemossa, Km. 7,5, 07071

Palma de Mallorca, Balears, Spain. fax 34 71 173190.

Second World Congress on Stress

Oct. 25-29, Melbourne, Australia. Contact: Sarah Hamm, tel +61 3 9682 0244, internet: <www.icms.com.au/stress98>.

Natural History of Addictions: Recovery from Alcohol, Tobacco and Other Drug Problems Without Treatment

March 7-12, 1999, Les Diablerets, Switzerland.
Contact: Harald Klingemann, Swiss Institute for the Prevention of Alcohol and Other Drug Problems (SIPA), C.P. 870, CH-1001 Lausanne, Switzerland, tel 41 21 321 295 5; fax 41 21 321 29 40; e-mail <hklingemann@sfa-isp.ch>.

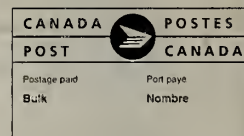
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Centre de
toxicomanie et
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The
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November/December
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Volume 1
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Homelessness:
crisis and response

Why the problem can't
be solved locally.

**Rendezvous
with
Madness**

Festival showcases
films on mental illness
and addictions



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**ALCOHOL AND
BAR VIOLENCE**

Can a public health
approach stop bar fights?

**MOOD DISORDERS
AND DISABILITY**

A new group offers
help and support

**METHADONE
IN PRISONS**

A mixed response to
the feds' new program



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Cover

The Rendezvous with Madness Film festival, which ran from November 18-22, featured the world premiere of *Completely Cuckoo*, a documentary about the making of the classic *One Flew Over the Cuckoo's Nest* and other films on mental illness and addictions. See story, page 3. Cover image by Ogilvy and Mather.





YOUR
time is
running
out!

**(See the attached
card for details.)**





VOUS
allez
bientôt
manquer
de temps !

**(Pour plus de détails,
voir la carte ci-jointe.)**



News from the Centre

The Centre for Addiction and Mental Health celebrated its merger during the first week in October. The Centre is the result of a merger of the Addiction Research Foundation, Clarke Institute of Psychiatry, Donwood Institute and Queen Street Mental Health Centre. Elizabeth Witmer, the Ontario Minister of Health, visited the Centre at an open house on Oct. 5. In addition, a special supplement outlining the work of the Centre appeared in *The Globe and Mail* on Oct. 8 and a fair, showcasing many Centre programs, was held later that week.

The Centre has begun a strategic planning process and has held a number of meetings and focus groups to consult staff, volunteers, clients, families and other stakeholders. Preliminary results from the consultations found consensus in several areas, including support for the following:

- the Centre's role in creating awareness and reducing stigma associated with substance abuse and mental illness
- providing clinical services in Toronto and Peel Region
- the Centre's role in training and education
- continuing role in research and a focus on "best practices"
- an advocacy role.

There were also a number of comments expressed in the meetings that reflected interest in the focus and work of the new organization. An interim Strategic Planning Discussion Paper will be available on the Centre's website at <http://www.camh.net/strategic_planning> after December 18, 1998 and we invite readers to provide feedback on the emerging vision for the Centre. Responses are welcomed. The Centre is expecting to complete its strategic planning early in 1999.

The Centre is committed to improving patient care, and a key to achieving that is to improve the management of patient information. The Centre is working on the development of the first-ever integrated clinical and operational information system in the mental health and addiction sectors. When developed, the system will give clinicians better access to patient information and will enable the Centre the ability to improve patient care through more informed decision making.

The Centre is also developing a balanced scorecard, again the first attempt in the mental health or addictions field to measure outcomes. The first one has just been completed and will be the benchmark for measuring its operations, efficiency and quality of care.



Letters

Watch your language

I received your *Journal of Addiction and Mental Health*, and enjoyed reading it. I feel that I have an understanding of the mental health field being a consumer and publisher of *Schizophrenia Digest*, but must admit I know very little about addictions.

I would like to make reference to an article on page 7 of your first issue, "Treatment orders show mixed results." At the end of the first column, the sentence reads "A total of 331 severely mentally ill patients who were being released from mental hospitals participated in the one-year study."

It seems to me that instead of using "mental" in front of hospitals you could have said psychiatric hospitals or psychiatric wards.

Believe me, I understand that political correctness is important. The first issue of *Schizophrenia Digest* that I published referred to people with schizophrenia as schizophrenics, and I was rightly made aware of it.

William J. MacPhee

Publisher, *Schizophrenia Digest*
Fort Erie, Ontario

Congratulations

Congratulations on your first edition of *The Journal of Addiction and Mental Health*. I must say I am extremely excited about this new publication.

As a full-time instructor for an addictions counselling training program, I was very pleased to read the informative and factual information on concurrent disorders.

I do have a couple of questions.

1) Why is this new Journal \$10.00 more for people residing outside of Ontario than for those who reside inside the province?

< DOWNLOADED >

"A drink is a drink — or is it?"

From the report "What is a standard drink?"

From:

- The International Centre for Alcohol Policies (ICAP) www.icap.org

The ICAP is a non-profit organization, funded by the alcohol beverage industry. Its site contains documents exploring alcohol-related issues. The report above, for instance, points out the wide range of official definitions of a standard drink, which makes international comparisons of drinking guidelines a challenge. For those in the alcohol policy field, it's a worthwhile site to be aware of.

Send letters to: *Journal of Addiction and Mental Health*, 33 Russell St., Toronto, ON, M5S 2S1, email <adubey@arf.org> or fax (416) 595-6892.

2) I noticed that there were a number of conferences listed in Canada and elsewhere which had already taken place. Perhaps you could delete the conferences which will be held prior to the Journal being published, or mail it to us sooner.

Again, please let me congratulate you on such a fine publication. I was anxiously anticipating the new publication, and to be truthful I was not let down. Please keep up the good work.

Gord Spurrell

Dartmouth, Nova Scotia

Note: The Journal of Addiction and Mental Health is published by the Centre for Addiction and Mental Health, which is funded in part by the government of Ontario. Therefore, the subscription rate is lower in Ontario. We will ensure that only conferences occurring well in the future will be listed from now on.

Good medical reporting

I found Kate Cowen's article on Prozac vs. placebo [in the September/October 1998 issue] especially interesting. It does all the right things a good medical journalist should do, ending with a finely honed journalistic synthesis, a specific conclusion that suggests what a science-oriented practitioner should do. It is one of those penetrating articles that can be underrated because it deals with a very familiar topic in a familiar way. It gets everything right.

You must be complimented for making a successful transition in a re-shaped organization.

Natan Polster

Editor and Publisher, *Adolescent Medicine*
Washington, DC

- Psychiatric Times: www.mhsource.com/psychiatrictimes.html

This monthly trade publication is a must for continuing education and professional development. Check out the current issue through the Mental Health Infosource (MHI) site, and remind yourself to make a monthly visit. In fact, you may want to visit the host site, <www.mhsource.com>.

- SANO: sano.arf.org

To both professionals and the public: In the merger madness, don't forget about the Substance Abuse Network of Ontario (SANO). Updated regularly, this site should be your first-stop for news and information about substance abuse.

SHEILA LACROIX

In Brief

Ecstasy causes brain damage

Ecstasy, a synthetic drug used at all-night rave parties, causes brain damage, a new study has found. Researchers at Johns Hopkins University did PET scans on the brains of 14 people who reported heavy use of the drug. They found damage to nerves in the brain that release serotonin, which is believed to help regulate mood, memory, perception of pain, sleep and other factors. The damage did not appear in a control group, and was more severe in people who used the drug more often.

Treatment order bill introduced

A proposal to implement "community treatment orders" (CTOs) was introduced as a private member's bill in the Ontario legislature in November. Bill 78, which has passed second reading, would allow forced medication on consumers judged to be "not competent." The bill also proposes enabling the police to apprehend people who fail to comply to the orders. The Ontario Ministry of Health has been considering CTOs. Saskatchewan is the only province currently using them.

Depression in older women

Depression among older women can increase their risk of death, equalling the risks associated with cigarette smoking, researchers at the University of California at San Francisco found. They tracked death rates of more than 7,500 women older than 67 years, reports Reuters. The depressed women had almost a 50 per cent increased risk of mortality in general, and an 80 per cent greater risk of dying of cardiovascular disease. More effort is needed to detect and treat depression to enhance lives and reduce mortality, the researchers conclude.

Teen marijuana users depressed

Teens who use marijuana heavily are more likely to report depressive behaviors or to run away from home. Among the teens who used marijuana weekly, 24 per cent had thought about suicide and 24 per cent had run away from home in the past six months, according to data from the 1994-96 U.S. National Household Surveys on Drug Abuse. Users were more likely to be 16 or 17, white and living in an urban area in a single-parent home than non-users. The differences held after controlling for these factors.

Impotence an anti-smoking hook

Anti-smoking campaigns are beginning to capitalize on the long-known fact that smoking can cause impotence and fertility problems in men. "Cigarette smoking causes sexual impotence," reads a new warning label on packages in Thailand. A California campaign includes a commercial showing a limp cigarette with the message, "Cigarettes. Still think they're sexy?" The hope is that these messages will deter those who haven't been warned off smoking by threats of cancer, emphysema or heart disease. An estimated 17,100 Canadians will die of lung cancer in 1998, according to Health Canada.

Prozac not worth the cost

Prozac and similar anti-depressants cost much more than older anti-depressants, but their benefits of reduced side effects are relatively small, a new study in the *Canadian Medical Association Journal* suggests. Researchers looked at 84 clinical trials comparing Prozac and other selective serotonin reuptake inhibitors (SSRIs), with older tricyclic anti-depressants. Trials were all double-blind, random and controlled. Researchers say that there is still much to learn about SSRIs and side effects. SSRIs are not considered any more effective than older drugs, but are marketed as having fewer side effects. They cost at least seven times more.

Course fees may be restored

People living on federal disability pensions, including mental health consumers, may be getting their fee waivers for general interest

courses restored by the Toronto District School Board. Programs such as yoga, computers and cooking are important because they teach necessary life skills and boost self-esteem, says Chris Whittaker, executive director of the Consumer/Survivor Information Resource Centre of Toronto. Trustees will be reconsidering the September decision to force this group to pay full fees, says chair Gail Nyberg.

Medical marijuana supported

Citizens in five U.S. states voted in support of medical marijuana initiatives in November. The plebiscites support the prescription and use of marijuana for conditions including AIDS, cancer and glaucoma. In Arizona, voters reinstated a 1996 proposition that had been gutted by state legislature. In Oregon, citizens rejected a measure to recriminalize possession of less than an ounce of cannabis, in addition to supporting cultivation and possession for medical use. Alaska, Nevada and Washington state also passed similar initiatives.

Beer ads linked to teen drinking

Children pay more attention to televised beer ads featuring animation or celebrities than soft drink ads or public service announcements, and are at a higher risk of drinking more when they're older as a result, a 12-year study from the Prevention Research Centre in Berkeley, California found. A related survey of teens found they also paid greater attention to beer ads, and reported positive feelings about drinking as a result. Results were presented at the American Academy of Pediatrics meeting in San Francisco.



A 400-per cent increase in "air rage" incidents over the past three years is prompting airlines to develop a database of passengers to be banned from flights worldwide. Many incidents involve attacks against staff by passengers who are intoxicated or defiant of smoking bans.

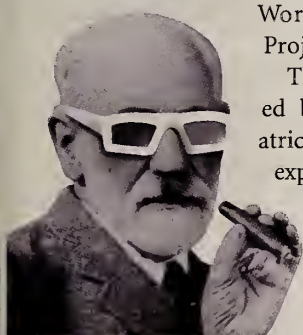
Film festival premieres *Cuckoo's Nest* documentary

The Academy Award-winning film *One Flew Over the Cuckoo's Nest* was ground-breaking on many levels when it was released in 1975. But perhaps its most remarkable achievement was that it was almost entirely filmed on location at a residential psychiatric hospital, using real patients and staff as cast and production crew.

Twenty years later, Charles Kiselyak returned to Oregon State Hospital in Eugene, the setting for his documentary *Completely Cuckoo*, to revisit the complex story of the transformation of this film from Ken Kesey's iconoclastic novel to Hollywood blockbuster.

Completely Cuckoo recently had its world premiere at the sixth annual Rendezvous With Madness Film Festival, presented by the Workman Theatre Project in Toronto.

The festival, founded by former psychiatric nurse Lisa Brown, explores the attitudes, mythology and facts surrounding mental illness and addiction through a



variety of documentary, short and feature films.

"It's a way to promote greater understanding of mental health through artistic means," she says, referring to the festival's post-film panels which usually include the film-maker, a psychiatric professional and a person using mental health services. "These discussions provide a little more insight into really complicated issues."

What Kiselyak discovered in making *Completely Cuckoo* was the hospital's open and progressive atmosphere that prospered under the administrator-of-the-day, Dr. Dean Brooks, had all but disappeared, erased by heightened bureaucracy, a controlling administration and the proliferation of barbed-wire fences.

"Nurse Ratched is now running the institute," says Kiselyak, referring to the cold antagonist of the movie. "I couldn't believe how regimented and bureaucratic it had become. *Cuckoo's Nest* could never have been filmed there today." His film crew had only the most limited access to the hospital's grounds, staff and patients, and were escorted by security guards wherever they went.

The film festival ran from November 18-22 at The Workman Theatre Project. Operating out of the Centre for Addiction and Mental Health,

the project is a non-profit theatre company that integrates people who receive mental health services with the professional arts community.

"From my point of view, I hope the festival serves as a way to educate and enlighten people," says Andrew Devey, a Workman volunteer who has used mental health services. "We try our best, but it's up to individuals to want to change their attitudes."

Other festival events included a panel discussion with Stewart Stern, screenwriter of the movie *Sybil*, and a screening of *Tu as crié: Let Me Go*, made by film-maker Anne-Claire Poirier after losing her daughter to addiction and prostitution.

Brown was especially pleased to present Kiselyak's documentary because *One Flew Over the Cuckoo's Nest* "had the impact of bringing mental health into the kitchen," she says.

"It shocked a lot of people with the electro-shock therapy scenes and with the way patients were treated in these places," says Devey, one of the festival programmers who chose *Completely Cuckoo*. "It put psychiatry on the defensive. I wish they had looked inward and asked why are these issues being raised, because I think a lot of that has continued even today." **KALYANI VITTALA**

Bring spirituality into treatment, MD says

DOCTORS AND ADDICTION THERAPISTS need to consider the spiritual needs of their patients and clients for there to be a complete recovery from alcohol and other drug problems, according to Dr. Raju Hajela, president of the Canadian Society of Addiction Medicine (CSAM).

Dr. Hajela presented a workshop with Dr. Richard Irons of the Menninger Clinic, Kansas, at the CSAM scientific conference in Victoria, BC, on applying psycho-spiritual principles to personal growth of people in recovery.

He hopes more doctors and therapists — followers of the "scientific paradigm" — will join him in bridging the schism with the "psycho-spiritual."

"The scientific community has neglected the spiritual side," says Dr. Hajela, also assistant professor in the departments of family medicine and psychiatry at Queen's University in Kingston. "However, if you talk to the gen-

eral public, they are very attuned to 'body, mind and spirit.'"

Spirituality is not synonymous with religion, but rather it refers to values, ethics and things that give meaning to a person's life. "This is something everyone has whether they are religious or not. Spirituality underlies psychology," he says. Addiction professionals are good at dealing with the physical and psychological components of treatment, but if they don't discuss spiritual needs, the recovery may not be complete. "We need to look at recovery beyond abstinence," he says.

A comparison to the 12-step movement and its call to a higher power is perhaps inevitable, but Dr. Hajela says he has a wider interpretation in mind. "It's an acknowledgement that there's more to life than just 'me' as an individual. It's the inner conscience as one connection to a higher power."

He feels stopping drug use is only the beginning of the process to regaining wellness. The

client and therapist also need to look at integrating into society. The process could include discussions, readings and use of music, with the aim of creating a sense of serenity.

In Dr. Hajela's experience, patients are willing to talk about their spiritual needs, but care-givers will sometimes avoid or cut off discussions because this subject doesn't fit their scientific paradigm. Allowing patients to talk, however, can open up discussions that can help the treatment.

Through discussion and encouragement, patients may reach spiritual insights themselves in their daily lives. "One patient told me about a virtual stranger who told her: 'You're judging me, but you need to look at yourself.' The patient interpreted this as a message from her higher power telling her that she has to take responsibility for her life."

He said that measuring the success of this treatment component is important, but objective measures are difficult for such a subjective experience. Instead, success can be measured through a qualitative assessment. **CRAIG SMITH**

Mending the cracks for dual disabilities

PEOPLE WITH DUAL DISABILITIES — physical disabilities and mental illness — fall between the cracks of the social service system. This statement has become something of a well-worn mantra over the years. However, a new project is reaching out to help people with a physical disability and depression or bipolar disorder.

The Mood Disorders Association of Ontario and Toronto, a non-profit self-help organization, and the Cerebral Palsy Association of Ontario have joined forces on a two-year project to offer monthly support meetings to people with disabilities and mood disorders. The group, *Going Beyond Disability*, had its first meeting in September.

"It is true, people do fall between the cracks," says Richard Miles, the project coordinator and group co-facilitator. Diagnosed with cerebral palsy at birth, Miles has also lived with depression for years. "Many mental health facilities are not equipped to handle our physical disabilities, such as wheelchair access, and mood disorders are often misunderstood and left untreated by those providing the medical care."

People with physical disabilities face barriers in the most basic aspects of daily life, such as getting someone to help them out of bed, finding a suitable place to live or even getting transportation to work, so it's possible many

are too exhausted to even seek help for mental health issues, says Vic Willi, executive director of Toronto's Centre for Independent Living.

Those who have sought help have faced difficulties, according to Scot McArthur of the Cerebral Palsy Association and group co-facilitator. "People with a disability often can't get a formal diagnosis of depression or manic depression," he says. "We've had a number of people tell us that they have been to [as many as] five different doctors and had not received the proper diagnosis and treatment. So, it's difficult to determine how many people have this dual disability."

According to Miles, the main reason for depression in people with a physical disability is isolation. "For many of us, our parents have passed on. We live alone and have few, if any, friends and family. Aging does not allow us to do the things we once did. Plus, transportation, housing, employment and conflicts with care-givers are all factors that can cause a great deal of anxiety."

Some individuals with a dual disability may also use alcohol, and illicit or prescription drugs to deal with their pain. "After the death of my parents, I thought life was not worth living and started to abuse alcohol," says Miles. "You think of it as a quick fix for your problems, but it only leads to deeper feelings of isolation and thoughts of suicide."



The group's goal is to provide members with information, fellowship and hope. "There's an obvious need for this service in Toronto and all across Ontario," says Neasa Martin, executive director of the Mood Disorders Association of Ontario and Toronto. "The first session [drew] 38 people, and 29 of them were in wheelchairs."

However, both group facilitators would like to see participation act as a springboard for members to move on and try other support groups. This, they hope, will help educate others. "We support integration, not separation," says McArthur.

For information, contact Richard Miles at (416) 486-8046 or Scot McArthur at (416) 244-9686. **GERRY LUCIANO**

Police officer calls for harm reduction

A new voice has joined the chorus calling for a harm-reduction approach to the illicit drug problem, and it wears a badge. Gil Puder, a constable with the Victoria Police Department in British Columbia, says he's trying to break through the code of silence and misinformation that has created an atmosphere that prevents frank talk about drug law reform in Canada.

"We have to start holding law enforcement officials responsible for the things that they say," he told a recent Fraser Institute-sponsored conference on *Sensible Solutions to the Urban Drug Problem* in Toronto, where he shared the podium with other critics of North American drug policy such as lawyer Eugene Oscapella and policy expert Ethan Nadelmann.

Quoting an RCMP spokesperson who told Vancouver newspapers that "the new marijuana is highly addictive... there are acts of aggression, leading to assaults and even murders," Puder countered, "Has this guy been smoking

his exhibits? What addicts? What murders? I've seen hundreds of pot smokers in my career, readily confess to some youthful marijuana use, and the only thing in danger of being murdered was a pizza."

Zero-tolerance policies and drug education programs that promote abstinence as the only answer are not only ignoring the evidence, Puder argues, but are also turning law enforcement officers into 'lifestyle police.' "To the detriment of good service, policing's preoccupation with morality makes blaming and fear-mongering more attractive than trying something constructive."

Unlike in North America, police in Germany, Switzerland and Australia have been on the forefront of promoting harm-reduction approaches that take a medical approach to drug use problems. For example, in Frankfurt, Germany police will connect users to services rather than arrest them. Police also support the city's "health rooms" where users can con-

sume drugs using clean equipment to prevent the spread of HIV and hepatitis C and keep needles off city streets.

Puder's outspoken criticism of police officials who spread misinformation has polarized some of his colleagues, and in some police circles has made him an outcast. He argues that the 'us and them' dichotomy is symptomatic of a dysfunctional police subculture which has a vested interest in keeping drug prohibition alive.

"The 'drug war' mentality of criminal enforcement promotes adversarial attitudes, which result in the abuses of force that I have spent so much of my career guarding others against. And it lets police do things that should be unacceptable in peaceful society."

While Puder's efforts are symbolically very important, the message now needs to be heard from officials higher up in the ranks, says Benedikt Fischer, a scientist with the Centre for Addiction and Mental Health. **MARK CRANE**

Mixed response to prison methadone program

Correctional Services of Canada (CSC) now provides methadone maintenance treatment in federal penitentiaries — but only for inmates with a previous history of methadone use.

Some see CSC's decision to introduce methadone programs as radical; others argue that treatment efforts are not going far enough — and that methadone, a drug that blocks the withdrawal effects of heroin — should be made available to any prisoner who needs it.

In this first phase of implementation, only offenders who are on methadone treatment at the time of admission or who have a history of methadone use in the community are eligible for the program. While Phase II calls for the inclusion of inmates who have no prior methadone use, this has yet to be implemented.

As such, "CSC is not following the recommendations made by the expert committee on AIDS in Prisons and the 1996 report by the Canadian HIV/AIDS Legal Network and Canadian AIDS Society," says the Legal Network's executive director Ralf Jürgens.

Methadone reduces the transmission of HIV and hepatitis C contracted through injection drug use. This is significant, given that the rate of HIV/AIDS infection in the prison population, at more than one per cent, is believed to be as much as 10 times greater than in the population at large.

Currently, there are about 85 to 90 of an estimated 14,000 federal inmates on the methadone maintenance program, according

to Steven Sternthal, a project officer with CSC's National HIV/AIDS program.

In other words, a very small percentage of inmates, says a contracted physician with CSC, who wishes to remain anonymous. While one exception was made for a man who confessed to sharing needles, the reality is that many share needles, the physician says. In the 1996 report, 11 per cent of inmates said they'd shared needles in prison.

"We don't do harm reduction well. We don't provide needles. And we expect abstinence, which is just not a realistic expectation for a chronic opiate addict."

The physician also says many inmates report starting heroin in jail, because it leaves the system faster than drugs such as marijuana. Therefore, it isn't detected in urine analysis tests, which would result in suspension of family visiting privileges. And unlike heroin users, people taking methadone seem more sociable, better able to finish school projects and participate in communal activities in prison, the physician says.

Yet for now, only a small percentage will be eligible to receive methadone — in part because many inmates may not have been out in the community since methadone became more widely available in the past few years, says the physician.

Inmates will have their methadone treatment administered by multidisciplinary teams of nurses, parole officers and substance abuse pro-

gram officers. This comes in the wake of former Solicitor-General Andy Scott's announcement last December that methadone would be allowed inside federal penitentiaries.

Compared to some provincial prisons, federal methadone programs have been slow to get off the ground. British Columbia has taken the lead, with some 600 inmates already treated with methadone since programs were established three years ago, says Dr. Perry Kendall, vice-president, Seniors' Capital Health Region in B.C. The province also voted to pilot a needle exchange program, but this was overturned by prison guards who worried they would be stabbed with syringes, Dr. Kendall says.

Ontario, Quebec and B.C. all have methadone treatment in provincial prisons, but like federal penitentiaries, it is only offered to those with a prior history of methadone use. **DIANA BALLON**



Placing blame for drunken violence

SHOULD A DRUNK PERSON WHO commits a crime against another person be held responsible for the offence?

While the average citizen would say "yes" and the Canadian government has passed legislation reflecting this view, the courts do not always agree with public sentiment and science. The legal system therefore faces a "messy status quo" in which intoxication can be a legal excuse in some circumstances, according to Dr. Robin Room, speaking at an Alcohol Policy Network lecture in Toronto in October. Room is a visiting scientist at the National Institute for Alcohol and Drug Research in Oslo, Norway.

In a 1995 survey of about 1,000 people that Room and colleagues conducted in Ontario, 78 per cent felt it that if a person had a few drinks, enough to feel the effects, they were likely to become aggressive and possibly violent. Yet

almost all — 97 per cent in a recent 1998 survey — felt that drunk people were still responsible for their actions.

"But the consensus ignores the problem of conflict with the general principle of criminal law — that there must be intent to commit a crime for an action to be a crime," he says.

This issue came into public focus three years ago, after the Supreme Court ruled that a drunk man who sexually assaulted a woman was not guilty. The court reasoned that the perpetrator was drunk to the point of being in an automatism state, and was therefore unable to form intent — even though there is no scientific evidence alcohol alone leads to automatism.

The federal government intervened to introduce amendments to the Criminal Code after four similar acquittals in the three months after the court decision. But there remain legal

exceptions, based on criteria involving "intent" and the nature of the crime.

Unfortunately, Room notes, the furore around the Supreme Court decision ignored another dimension of responsibility — the potential role of alcohol controls in limiting intoxicated violence. Here again the public often draws a connection that has been missing in public discussion.

The public supports alcohol controls, particularly among those who believe alcohol leads to violence, the research found. "If you think drinking is going to make others more aggressive and lose control, you're more likely to be in favor of alcohol controls," he says.

Room concludes that discussion on the alcohol-violence link needs to be initiated, and that seminars need to be held with judges, lawyers and researchers to exchange knowledge on crime and research findings. **ANITA DUBEY**

CD speaks to teens in distress

"*Mauve* is our CD-ROM. It's all about us teenagers. It says what we have to say — in our own language — to help each other out. It isn't meant for kids or for adults."

And so begins the new interactive compact disc, *Mauve*, created by the partnership team of Health Canada, Médiapaul and Pentafolio Multimedia and designed to promote mental health. Aimed at 12- to 18 year-olds struggling to cope with such life issues as identity, love, school, depression, stress and work, it's an educational tool that broadens the portfolio of interventions care-givers working with teens might employ when conventional means of communication have proven ineffective.

"Adults are cool, they can be," says one of the teens on the disc, "they just have to talk to us at our own level... they have to learn to comprehend us, to understand us."

Mauve aims to foster well-being and mental health in teens by showing them that they are not alone in their worries, by helping promote dialogue with others, and by showing that drugs, alcohol and suicide aren't coping mechanisms.

Beginning with an image of a bleak grey wall and a sparse soundtrack that seeks to capture a teen's mood of despair, the user proceeds through a series of screens tackling life's issues. The messages provided are life-affirming, but are also presented in a candid and eclectic manner ("but [drugs] have some bad effects too... I have really bad short-term memory"). One teen relates, "having friends is the most important thing when you're a teenager because parents can never understand you like your friends can."

Mauve contains abrasive quotes from teens who have negotiated situations the navigator might identify with ("I think that pot isn't a dangerous drug any more so than nicotine, or coffee or alcohol... everything has to be used responsibly"). It then balances its messages with disguised sound advice, managing to educate without preaching, and entertain without trivialising.

Still, any project that attempts to talk to teenagers on their own terms risks missing the mark completely. But according to Anouk Lavoie-Orlick, a 19 year-old who assisted in



this project from its inception three years ago, *Mauve* has managed to avoid this pitfall. By ensuring that teens were involved in all aspects of the project, from research to critical feedback, she feels the result was an honest reflection of what Canadian adolescents are experiencing and will be recognized as such.

For more information and to order a copy of *Mauve*, contact Pentafolio at (613) 488-3920 or <www.pentafolio.com>. **CHRIS HENDRY**

Highlighting the needs of deaf clients

FOR A DEAF PERSON, SOMETHING simple — a trip to the doctor, or dealing with a landlord — can be fraught with difficulty. There's always a risk of being misunderstood or labeled as being "slow."

Finding help for more complex mental health issues — depression, addiction or abuse — can be even more daunting. There's a risk of being misdiagnosed or receiving the wrong medications, or that the animated expressions involved in signing might be construed as agitation, thought disorder or psychosis.

In October, 450 professionals met in Washington DC for the first world conference on deafness and mental health. From the effects of bullying in childhood to the controversial issue of cochlear implants for bringing sound to deaf children, *Coming Together for a Better Tomorrow*, sponsored by Gallaudet University Mental Health Centre, explored a range of issues.

Even the complexity of staging a three-day program with hearing and deaf participants from around the world left delegates touched.

"You start to understand a bit of what it means to be deaf and what you have to set up for deaf people to participate in the hearing

world," says Karen Frayn, manager of CONNECT Counselling Services of the Canadian Hearing Society in Toronto.

Treatment strategies generally need not be different for deaf people, as conference participants described how therapies including solution-focused therapies and psychoanalysis were successfully being used.

René Rivard of Cornwall's Eastern Ontario Council on Mental Health and Deafness presented a paper at the conference describing how understanding non-linear thought processes — used in sign and Oriental languages — could help therapists more easily adapt counselling techniques for deaf people. Most hearing individuals in North America organize information in a linear way (i.e., writing) whereas deaf individuals organize information spatially around them in three dimensions (i.e., sign language).

A more pressing issue, though, is not about how to deliver treatment to deaf clients, but about access. Rivard was struck by the wide array of services available elsewhere. "I really feel almost ashamed of being Canadian when I go to these things because I feel that we are so much farther behind," he says.

Only two Canadian centres are dedicated to providing treatment for deaf people with mental health issues, which are CONNECT's outpatient program in Toronto, and the Deaf/Hard-of-Hearing/Deaf-Blind Well-Being Program in Vancouver. For addiction treatment, people must apply to centres in the U.S., and few are successful in getting referrals, Frayn says.

Even participation in self-help groups is not straightforward. "To get a person into Alcoholics Anonymous, they need an interpreter," says Hayn. "But groups are 'closed' to outsiders, so does the interpreter need to be in recovery, too?"

It is hard to get statistics on the prevalence of mental illness in the deaf community, Rivard adds, because few psychiatrists are able to perform an appropriate evaluation. In Ontario there are about 120,000 deaf people, says Frayn, and many who may need treatment for an addiction or mental health problem likely go without help.

"We are totally dependent on partnering," she says, adding that finding the time and opportunity to develop more partnerships with agencies is needed to enable expertise to reach the deaf community.

CONNECT's number is (416) 928-2511 (TTY) or (416) 928-2512 (voice). **PENNY STUART**



Kids over-prescribed drugs

Infants and preschool children are increasingly being prescribed psychotropic drugs to treat common behavior problems, but not necessarily appropriately. A literature review found that methylphenidate (Ritalin) prescriptions in Canadian school-age children increased by 300 per cent over a four-year period. In the U.S., there was a large increase in prescribed SSRIs, sertraline (Zoloft) in particular. In France, chlorpromazine, magnesium and benzodiazepines were most often prescribed, but none have established clinical relevance in preschoolers, the authors state. None of the psychotropic drugs have been evaluated for their safety in children, nor been recommended by regulatory agencies. There's also "no evidence" that these medications are helpful in behavioral difficulties for which they were prescribed, such as sleep problems, feeding disorders or general behavior problems.

Canadian Journal of Psychiatry, v.43, 571-575. K. Minde, Dept. of Psychiatry, Montréal Children's Hospital, Montréal, Québec.

Problem gambling a family affair

Genetics help explain roughly 50 per cent of a person's likelihood of becoming a pathological gambler, according to an analysis of more than 3,300 twin pairs. Evidence suggesting that vulnerability to pathological gambling is inherited, at least in part, was revealed following interviews with twins from the Vietnam Era Twin Registry of male fraternal and identical twins. Only 1.4 per cent met DSM-III criteria for pathological gambling. Of those twins who reported gambling at least 25 times a year, inherited factors explained 48 per cent of

reports of one or more symptoms of pathological gambling, and 54 per cent of reports of two or more symptoms. Results are supported by other biological research showing physiological changes in problem gamblers, as well as the role of inherited factors in disorders related to pathological gambling, such as depression, alcoholism, antisocial personality disorder and anxiety disorder.

Addiction, v.93(9): 1375-1384. Seth A. Eisen et al, Veterans Affairs Medical Centre, St. Louis, Missouri.

Effect of cognitive therapy

Findings that cognitive behavioral therapy (CBT) effectively prevents relapse in depressed patients challenge the assumption that long-term drug therapy is the only way to go. In a preliminary study, patients who had been treated with CBT for 20 weeks had a significantly lower level of residual symptoms and a significantly lower relapse rate of 25 per cent, compared to 80 per cent for patients in basic clinical care for 20 weeks. The average length of time to relapse was 92 weeks for the CBT group and 62 weeks for the clinical management group. Forty patients were involved, each with a history of three or more episodes of depression. Following successful drug therapy, patients received either CBT (plus lifestyle modification and well-being therapy) or clinical management. During the 20-week experiment, antidepressant drug use was tapered and discontinued, and no further antidepressants were given during the two-year follow-up unless the patient relapsed.

Archives of General Psychiatry, v.55:816-820. Giovanni A. Fava et al., Dept. of Psychiatry, State University of New York at Buffalo, Buffalo, New York.

Motivation helps angry clients

Clients high in anger were more likely to abstain from alcohol use if they had received motivational enhancement therapy (MET), as opposed to either cognitive-behavioral or twelve-step facilitation treatment. Project MATCH, the largest treatment study of its kind, looked at 21 client attributes, such as motivation, anger and severity of psychiatric illness, to determine which ones should be used as the basis for referral to different treatments. There were only a few matches. At a three-year follow-up of 806 clients, those high in anger had an average of 76 per cent days of abstinence if they had received MET, versus 66 per cent for other treatments. Conversely, clients low in anger fared better in the other treatments. MET, which is non-confrontational and uses strategies to defuse client resistance, had also been effective at one-year follow up. Another finding was that clients who had strong social support for drinking had higher abstinence rates after three years — but not after one year — if they had received twelve-step facilitation, which encourages members to join Alcoholics Anonymous.

Alcoholism: Clinical and Experimental Research, v. 22 (6): 1300-1311. Project MATCH Research Group, c/o Scientific Communications Branch, National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland.

Risk behavior predicts depression

Teens who were involved in "risky" behaviors such as substance use, trouble at school and other misconduct showed a higher increase in depressive symptoms two years later than teens who weren't initially involved in such behaviors, a Nova Scotia study found. A study of 131 young people aged 12 to 17 twice asked students, in sessions two years apart, to fill questionnaires to assess anxiety, depression and involvement in risk behaviors. Teenagers were likely to show signs of depression if they also reported high rates of anxiety symptoms and "risky" behaviors at the second sessions, confirming other research. Researchers were surprised, however, that initial reports of anxiety symptoms did not predict change in depression two years later. The findings stress the need to collect information on a range of symptoms when assessing young people.

Canadian Journal of Behavioral Science, v.30(4): 225-233. Heather A. Sears et al., Dept. of Psychology, University of New Brunswick, Fredericton, New Brunswick.

Predicting seniors' drinking problems

What risk factors lead people to develop drinking problems later in life? In following a group of non-problem drinkers aged 55 to 65, researchers found that, after seven years, 77 reported drinking-related problems, while 197 remained non-problem drinkers. Using various surveys to assess drinking levels, life stressors, social resources, depression and other factors, the study found that problem drinking could be predicted by certain characteristics. Initially, the problem drinkers were more likely to report life problems, to cope with problems by avoiding them, to have friends who approved of their drinking, and to smoke and drink more. They also had fewer serious medical conditions complicated by alcohol use, and a history of responding to stress with increased drinking. One explanation why drinking problems develop later in life may be because older adults' bodies metabolize alcohol more slowly, so consuming the same amount may produce greater negative effects.

Alcoholism: Clinical and Experimental Research, v.22(6): 1349-1358.

Kathleen K. Schutte et al, Centre for Health Care Evaluation, Veterans Affairs Palo Alto Health Care, Palo Alto, California.

New antipsychotics promising

The new atypical antipsychotic medications may finally enable physicians to tailor treatment to individual patient needs and improve quality of life for those with schizophrenia. In a review of these new agents, the primary advantage was fewer side effects, "which touch virtually every domain in schizophrenia including short and long-term movement dis-

orders, negative symptoms, non-compliance, relapse rate cognitive dysfunction and dysphoria." Although roughly comparable in effectiveness to the older agents, the new drugs — including olanzapine, risperidone, clozapine and quetiapine — reduce negative symptoms and improve cognition to a greater extent than the older agents. Pharmacological and clinical differences do exist between the new agents. However, once these are fully recognized, "the drugs' unique profiles may make it possible to tailor treatment to patients and lead to superior long-term outcome."

Journal of Psychiatric Research, v. 32: 215-228. Michael D. Jobson et al., Dept. of Psychiatry, University of Michigan School of Medicine, Ann Arbor, Michigan.

Coping with schizophrenia

Long-term follow-up of patients with schizophrenia indicate that they remain significantly affected by their illness, despite continuing care from their families. Further, those who care for them are also subject to ongoing distress. Researchers followed 179 patients with schizophrenia who lived with family. Fifteen years later, of the remaining 134 who had not died or been lost to follow-up, 55 per cent still lived with their families. Another 23 per cent had been institutionalized and 19 per cent lived alone. Two per cent were homeless. However, there was little change in the level of either clinical or social effects or care-giver distress over the same period, the authors note. Just eight per cent of patients had paid employment. Two-thirds of the survivors had also been re-admitted to an acute psychiatric

ward during follow-up. "Mental health services should seek to support families who want to care for relatives with schizophrenia," the researchers suggest.

British Journal of Psychiatry, 1998, Steve Brown et al. 139-143.

Enhanced treatment improves life

Case management services, combined with addiction treatment, not only reduced clients' substance problems, but also helped improve other health and social factors. Philadelphia researchers went a step beyond previous clinical studies by looking at the effects of additional services in a more realistic "field" setting. They also examined how extra services were implemented in both abstinence-based and methadone maintenance programs. Eight programs offered enhanced care, providing help for medical screening, housing, parenting classes, employment, etc., while four programs served as control groups, offering addiction treatment only. Although clients in all groups reduced substance use, the enhanced group was more than twice as likely than the control group to be abstinent at six-month follow-up, and only 10 per cent as likely to have been retreated for addiction. The enhanced group also had significant improvements in the number of days working, income earned, family issues and legal problems.

Addiction 93(10): 1489-1499. A. Thomas McLellan et al, Treatment Research Institute, University of Pennsylvania, Philadelphia, Pennsylvania

Counsellors question drug therapy

Addiction counsellors believe cognitive-behavioral approaches are essential for treatment, but do not support use of pharmacological agents, a survey of 663 front-line staff in Ontario found. Staff were asked to indicate the extent to which each of 53 approaches were necessary for effective treatment of substance use problems. They supported approaches based on cognitive use, coping and relapse prevention, and also believed in providing information on community resources, in seeking client feedback, and in providing treatment of mental health problems. These beliefs are supported by research. However, there was little support for use of antabuse, methadone and other medications to control cravings, even though their effectiveness has also been supported by research. This suggests a need for more education, the researchers note. Support for principles of Alcoholics Anonymous and the disease model of dependency was mixed.

Journal of Substance Abuse Treatment, v.15(4): 301-312. Alan C. Ogborne, et al. Centre for Addiction and Mental Health, UWO Research Park, London, Ontario.



Telemedicine

Video counselling reaches the underserved, but still has to prove its worth

BY DONALEE MOUTON

cent of psychiatrists said the telepsychiatry service was either very good or good.

A key to a successful session is to establish trust, says Chris-Anne Ingram, IWK Grace's telehealth co-ordinator. Patients are encouraged to ask questions about video-conferencing before any consultation begins. Medical records are kept the old-fashioned way: psychiatrists write their notes on paper.

Issues such as consent and confidentiality are dealt with by adapting existing processes. Health care facilities do have to be careful, however, that transmission lines are secure from eavesdroppers.

For the psychiatrists at the IWK Grace and the Centre, telepsychiatry occurs with a mental health team that is located in or near the patient's home town.

"There is somebody on site who will be responsible for the [patient's] care and ongoing health. We will be consultants to them," explains Dr. Orlik.

As consultants, psychiatrists are usually called to help in two types of situations. First, they conduct assessments of high-risk patients. Second, they conduct follow-up visits. The initial visit, ideally, is done in person.

"There's a natural desire to get to know each other and sit together. There's a natural worry you may miss out on something [with telepsychiatry]," says Dr. Orlik. "It's harder to establish that trust through video conferencing."

Dr. Farewell agrees. "It's preferable, all things being equal, to have the patient in front of you — and that's not likely to change with increased technology."

It is likely, however, that use of telepsychiatry will continue to grow. Three factors are working in its favor. First, there is a greater reliance on and comfort with technology among patients and health care professionals. Second, the fixed costs of telepsychiatry are coming down — dramatically. A decade ago the cost of setting up and equipping remote links would have added up to \$20,000 to \$100,000 (U.S.) Today those costs range from \$500 to \$3,500 (U.S.).

Finally, in an age of cost-cutting, health departments are being pressured to make decisions based on the bottom line. By next spring, for example, Nova Scotia will be the first province in the country to have every hospital linked through an extensive telemedicine system designed to improve access and reduce costs. ■

PSYCHIATRISTS ARE DEPENDING MORE and more often on technology to enhance treatment. Nowhere is that dependence more apparent than in telepsychiatry. It's uncertain at this point, however, whether the dependence is a healthy one.

There's no doubt that telepsychiatry — the use of video conferencing and other equipment to help assess and counsel patients in remote locations — enhances access. It literally brings mental health services to communities and families that would otherwise go without services, or who could only be treated in time-consuming and costly ways.

It is often hard for psychiatrists to get to smaller communities, or for many families to get into an urban centre, says Dr. Herb Orlik, a child psychiatrist with the IWK Grace Health Centre in Halifax, Nova Scotia.

Since the body of scientific evidence showing the effectiveness of telepsychiatry is small, some researchers suggest its use be limited to underserved areas.

The IWK Grace, which operates the largest telepsychiatry program in the country, does have a travelling medical clinic that brings psychiatrists to smaller communities.

But travelling is a time-consuming process, notes Linda Weaver, chief technical officer with Halifax's TecKnowledge Healthcare Systems. "When you have a shortage of specialists," she adds, "having them travel is a waste of their time."

It may also be more expensive, although the jury is still out on the cost-effectiveness of telepsychiatry versus traditional psychiatry. In a report prepared by the Provincial Mental Health Advisory Board in Alberta to evaluate its telepsychiatry program involving six hospitals, the authors note that, in addition to saving direct travel costs, telepsychiatry also has the potential to increase caseloads, reduce the number of consultations and decrease the number and length of hospital stays.

The authors estimated that total variable costs for one consultation for a travelling psychiatrist was \$610. For a telepsychiatry consultation, this figure dropped to about \$180. This comparison, however, did not take into account fixed costs associated with telepsychiatry such as equipment and long-distance charges.

In terms of its effectiveness, researchers who conducted a literature review concluded that the "evidence currently available is insufficient to suggest its widespread implementation." Their report, published in the *Harvard Review of Psychiatry* last year (v.5, #1), called for more research on what age groups and conditions it could be used with, and recommend restricting use to research and underserved communities.

For patients and their families in such communities, there's no doubt that telepsychiatry saves both time and money. There is no need to take a day off work, no need for child-care services, no travel costs.

But even more than this, notes Dr. Orlik, is peace of mind. Travelling with a patient who is ill can be very traumatic. For example, for families with disruptive children or autistic children who do not handle change well, a five-hour car ride can be a nightmare, if not an outright impossibility.

Interestingly, the technology itself seems to pose only minor problems for patients and their families. There is a lag in voice responses, and you can't see all of the person's body, notes Dr. John Farewell, director of televideo services at the Centre for Addiction and Mental Health in Toronto.

But, he adds, generally there is a positive feeling similar to what both parties would experience if they met in person.

In its report, the Alberta advisory board notes that 84 per cent of consumers surveyed said they were satisfied at the time of the consultation. All agreed that they would use video counselling, rather than wait to get help by seeing a psychiatrist in person. Overall, 77 per

Violence in bars

BY ANITA DUBEY

IN WINDSOR, ONT., A JUDGE ORDERS A tavern to pay a man \$548,000, after other bar patrons beat him up when they were thrown out of the bar at the same time.

• In Kitchener, Ont., city councillors are so fed up with rowdiness around several downtown bars, they want owners to pay extra policing costs.

• In Calgary, Alta., a doorman who broke a man's neck at a bar is sentenced to 18 months of community service to speak to other "bouncers" about his actions, while a London, Ont. doorman gets 30 months in jail for beating a man so badly he is confined to a wheelchair.

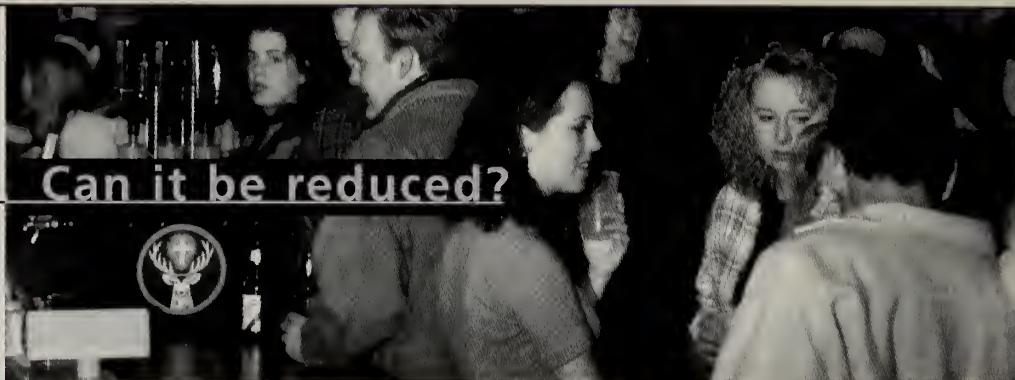
The incidents hit the headlines with regularity, often describing the most violent and tragic cases. Researchers from the Centre for Addiction and Mental Health are now studying how to take a public health approach to prevent aggression in bars before it escalates into newspaper headlines.

"Bars are the second most likely place, next to the home, for incidents of alcohol-related violence," says Dr. Kathryn Graham, senior scientist at the Centre's London research department. "But unlike violence that happens in the home, aggression in bars can be studied more easily using direct observations. And because bars are regulated through licensing, there are more avenues for prevention."

To see what they were facing, the research team, headed by Graham, dispatched pairs of college-aged males and females to 12 large bars frequented by young people in London. These bars were identified by police and others as posing a high risk for violence.

There were 133 alcohol-related aggressive acts over 93 nights, observed from midnight to closing on busy nights. The incidents ranged from verbal insults to fights or brawls. Researchers identified 11 categories of incidents leading to aggression, such as rule breaking and enforcement, jealousy and possessiveness, rough dancing, accidental bumping, and insults and offensive behavior.

Scientists agree there's no single cause for alcohol-related aggression. However, many incidents in these bars appeared to develop for no reason at all, apart from what researchers called "male challenging." A typical incident: "Man accidentally bumps another man, who gets angry. Second man and friend push first man and challenge him to fight."



An emergency room study of violent injury found that 37 per cent of patients had been in a bar or restaurant before they were injured, and 84 per cent had alcohol in the past six hours.

How can such incidents be prevented? One Australian study found it was important to target broader risk factors, such as how security handles aggression, the permissive atmosphere that tolerates rowdiness, and bar crowding that leads to bumping.

"We need to look at prevention in a much broader perspective," says Graham. Until now, public health efforts have focused largely on server training. "Bars have changed considerably in the last 15 to 20 years, since server intervention was created," she says. "It is not so applicable in large bars where people wander around, and one person in a group often obtains drinks for others from a bartender."

In today's "monster" bars, which accommodate hundreds, it's security staff who play a large role in deflating — or exacerbating — acts of aggression. Sixty-three per cent of incidents in the study involved security in some way.

"Your doorman sets the tone," says Mark Mishriky, a London bar owner. If your doorman is violent, the bar will be violent."

Doormen can also help monitor drinking better than serving staff. "Serving staff are so busy, they barely have a chance to glance around," says Mishriky. "Doormen are the ones who really have a chance to keep a look out for potential problems, for overserving, for thefts."

A team at the Centre, headed by Graham and program director, Christine Bois, has used the London research findings, along with examples of Australian and British initiatives to develop a Safer Bars program, working with police and public health units across Ontario.

One component, a risk assessment, asks bar owners to rate the safety of their bars, looking at details such as how people enter, the atmosphere, layout, rules, serving, and how problems are handled. For example, one question asks if staff monitor the area outside the bar to prevent problems as people leave. The explanation: "You are still responsible for the behavior of the people to whom you served alcohol — even after they leave the bar."

Other parts of the program are still being developed. These include a training program

— which has been tested with bar staff in five cities — plus a participant's workbook, a video on aggression, and a pamphlet summarizing the legal issues relating to bar violence.

The results of an Australian study suggest that prevention can work. Alcohol-related violence dropped significantly with a similar project with 18 bars in Surfers Paradise. The project, which ran in 1992-93 with heavy community involvement, targeted factors such as crowding, cheap drink promotions, male rowdiness, availability of food, tolerance of sexual behaviors and criminal incidents outside bars. It also included training, a risk assessment policy checklist and direct observation.

A year after the project was implemented, bar crowding was observed to have dropped from 23 per cent of observations to seven per cent, and levels of male rowdiness dropped from 39 per cent to 19 per cent. The bars were cleaner, had better access, and more and friendlier security staff.

An appeal to the business side helped draw in Australian bar owners, and a similar approach may be needed here.

"Unfortunately, the hook to get people's attention is their personal liability," says Jacqueline Gahagan, health promotion specialist with the Windsor-Essex County Health Unit. "Bar owners take offence. They see it as a much bigger problem than just what goes on in bars, such as young people drinking in parking lots before they get to the bar."

Ontario's new Mandatory Health Programs and Services Guidelines, released in February by the Ministry of Health, direct health units to become involved in workplace issues. This gives them an opportunity to work with bars. Typically, bars have been monitored by police and liquor inspectors, often with a mutual mistrust, says Patricia Metcalf, a public health nurse with the Toronto Department of Public Health, Scarborough office.

"But if you talk to everyone individually, they're all working toward the same goal," she says. "Bar owners don't want violence and drunkenness and liability either." ■

focus on the homelessness crisis

Why the problem can't be solved locally

BY TAMSEN TILLSON

THE PLIGHT OF THE HOMELESS IN CANADA HAS LEAPT ONTO the TV and front page of newspapers. The extent of the problem is clear — that more than 3,000 people used emergency hostels in the Toronto area on a typical night last year — 66 per cent more than in 1996. As many as 500 people in Canada's largest city will be spending the night in the winter cold because emergency shelters are full.

Today, few would claim that homelessness is not a problem — least of all Toronto Mayor Mel Lastman, who did so before local elections last year. In the fall, Toronto's city council declared homelessness a national disaster worthy of emergency humanitarian relief. There are municipal and provincial task forces on homelessness. The federal government announced it will form a committee on homelessness, and has opened a federal armoury to be used as a temporary shelter.

While the awareness is heartening, it is a partial and short-term victory in the eyes of front-line workers and homelessness experts. "I think people have been relieved to hear this named for what it is," acknowledges public health nurse Cathy Crowe. But Crowe and other activists contend that awareness does little to address the roots of homelessness. The key to any real, lasting improvement, they say, requires the mutual co-operation of all levels of government. And so far, that's not happening.

Frustrated by the lack of movement, health and community workers, AIDS activists, former homeless people, housing experts, academics, and churches, calling themselves the Toronto Disaster Relief Committee, came together last summer to lobby for change.

"People are travelling, trying to find any place that might be better," says spokesperson Beric German, noting that 47 per cent of shelter users in Toronto are from outside the city, and in many cases from outside the province. "Without dealing with this on a national level, you're going to continue that flow."

A higher level of support is needed to follow through with other issues related to homelessness, such as human rights, says John Fraser of the Centre for Equality Rights in Accommodation. Fraser works with prospective tenants who have trouble getting housing. "Definitely at the provincial level we need a strengthening of human rights protections" — a provincial responsibility — "because the degree and the blatancy of discrimination in the housing market would never be tolerated in other areas. It would never be tolerated in employment, for example."

German stresses the importance of treating homelessness holistically, in conjunction with other problems such as drug use, poverty, mental illness and unemployment. "A person who is homeless or even living in the stressful conditions of a hostel simply cannot be successful in a treatment program," he says.

Outreach workers, says Crowe, are overloaded. In the course of her 15-hour days providing health care to people without housing in Toronto, she has found disaster literature more relevant to her work than the standard nursing techniques she used to rely on. She is frus-



PETE DAKO

trated by the delays and lack of communication among the federal, provincial and municipal governments. Government attempts to off-load the issue to front-line workers are untenable. "I don't know if you're misinformed or cruel," she told MPP Jack Carroll, chair of an Ontario task force on homelessness when its report — making it clear the province would not be getting back into the affordable housing business — was released in October. "The governmental level is the only one that can respond to this disaster."

A similar conclusion, arrived at by different means, comes from policy expert Dr. Thomas Main, a professor at the school of public affairs from Baruch College at the City University of New York. Main has studied homelessness for 15 years, and recently completed a comparative study of homelessness in New York City and Toronto. Main concluded that effective change can come only from the top.

"I think the key thing to getting a co-ordinated policy in Canada is getting a federal government that's committed to doing something about homelessness," he says, adding change will be unlikely otherwise. Because Canada has a parliamentary system which centralizes power, a change to the system has to be done at the central level. "That's more important in Canada than in the U.S." Ironically, the U.S. federal government provides stronger policy direction on homelessness through legislation and funding.

The next immediate step for activists would be for the provincial and federal governments to give the disaster label the nod, so that those who need it could access the same emergency services that were rolled out after the ice storm in Quebec and Eastern Ontario, and the Manitoba floods. So far, that response has failed to materialize. ■

John Trainor - program manager, Community Support and Research Unit, Centre for Addiction and Mental Health, Toronto

I've worked in this field for 17 years and have seen this problem change — mostly grow. The current government wants solutions based on the market, but the market can't work for you if you don't have the money to pay the rent. Many people don't have enough money to even participate in the housing market. Very few mentally ill people, given a chance at a reasonable place, will select to be homeless. And most have the capacity to live on their own, with support. With rents in the \$700 range, it's impossible to have your own home on welfare. You'd be paying more than your entire cheque. I think we need to get housing going with the private sector, but government needs to make a few guarantees. A rent subsidy would be my suggestion. Even the most dynamic market can't afford to build housing for people that can't afford to pay the rent. You also need specific strategies for different needs, not one big solution. You want small niche-style housing, with outreach support for some and supervised accommodation for those who need it. Still, the central truth is affordable housing. I really could see a future with people from mental health agencies, banks, private developers and government all sitting around a table. Together, we could all start building.

Smaller cities cope with homelessness

EVERY EVENING, STAFF OF THE KENORA NATIVE STREET PATROL hit the streets in downtown Kenora, seeking people who might harm themselves or freeze to death in the cold northern night. Alcohol or solvent abuse are often involved.

It sometimes seems like a revolving door, says patrol co-ordinator Jim Chicago. Since 1994, when Bill 47 removed the ability of courts to force rehabilitation of people convicted of public intoxication, the numbers of clients rose from 1,580 to over 3,500 per year. Lately, the faces are getting younger. "You see people on the street who shouldn't be there," Chicago says.

Similarly, lineups at Shelter House in Thunder Bay have been growing longer. As chilly October nights arrived, the shelter, which has space for 35 people, provided floor space on mattresses for an additional five to 15 people who had nowhere else to go.

One reason for the increase, says executive director Rob Barrett, is simply that people are slipping into poverty. As jobs, particularly lower-paying jobs, become more scarce and the criteria for welfare tighten, these newcomers to poverty are added to the traditional users of shelters. Even when people find jobs, it can take much longer to re-establish themselves. "This facility, which is supposed to be a short-term crisis centre, is becoming long term," Barrett says.

Most Canadians tend to think of homelessness as predominantly a problem of large cities. Yet, the Ontario government's Provincial Task Force on Homelessness report, released in October, heard that many smaller centres, such as Kenora and Thunder Bay, are struggling to provide services. They also worry that the trend of seeing more homeless youth, more unemployment and changes to the province's mental health services could make lineups even longer in future.

Homelessness tends to be less visible in smaller centres, particularly in the north, says Genevieve Gibbons, manager of services at the Canadian Mental Health Association, Sudbury district. "The cycle is more hidden in the north. It is hidden in the homes of friends and family members," Gibbons says. Extended family and friends tend to help out, or doors are left unlocked so people have access to warm hallways.

Recognizing the problem, Sudbury set up an advisory committee in 1995. Since then, a house was opened for homeless youth and the situation has stabilized, Gibbons says. Community agencies, like others



Carolynne Pratt - former shelter user and psychiatric patient.

My life has been quite a journey. I've gone from being homeless to owning my own home. About eight years ago, I went to a women's shelter after leaving a 23 year marriage. I'd already had years of psychiatric hospitalization, six months at a time. I've had 15 different psychiatrists and at least that many labels. When you've been through the psychiatric system, too often the professionals don't really listen to you. Or they pay too much attention to the medication and not enough to the person. It takes a lot of patience to help patients, but nothing can be done without it. The people at the shelter had a lot of faith in me. After eight months, I took my disability pension and started out on my own. I firmly believe that some people may need a group home, but most can live on their own with support. I maintained contact with the shelter's outreach program and their non-institutional style of counselling really helped. We'd have our sessions over coffee or in the park feeding ducks. I went back to school. As a child I was considered retarded. The shelter's workers found out I was actually dyslexic. I went from grade seven to being a college graduate in five years. It baffles me when I walk into my home and remember that I was once told I would never leave a hospital.

across the province, are pulling together to develop home-grown programs.

The task force noted that response at a municipal level can vary dramatically — from establishing hostels and services to reconnect people to the community, to suspicions of "Greyhound Therapy," providing homeless people with a bus ticket to another jurisdiction.

"Some municipalities clearly fear that providing services will attract homeless people from elsewhere," the report notes. "Even in municipalities that are committed to providing substantial resources to addressing homelessness, services are typically delivered independently rather than as part of a comprehensive local plan."

With an estimated 20 per cent of people without housing suffering from a mental illness, the closing and restructuring of psychiatric hospitals across Ontario have added to the worry that front-line organizations will have a harder struggle to fill the gaps. Those with chronic mental illness can be particularly vulnerable in smaller centres because it is easy to become well known and unwelcome as a tenant. And services can be inconsistent, because smaller agencies may not have staff trained to deal with clients who are seriously ill, Gibbons says.

Worst hit by mental health reform, says Barrett, may be those people who require acute mental health care, who have traditionally used hospitals to become stabilized before re-entering the community. PENNY STUART

Kathleen Peyton — resident, Toronto's Street City Residence

I'm 42 years old. I've been at Street City for two years and I can't get myself out of here. I used to share an apartment with my mother until she had a stroke and was disabled. It was Ontario housing and I wasn't on the lease so I had to leave. Before I came here, I spent nights all over the place. I stayed in the park a couple of times. Stairwells and stuff like that. Here we pay \$325 for a room. I get \$520 from general welfare, so there's not much to live on. We have to go to places where they give out food. I'd like to have a job, but I guess I need some training. I'd do just about anything. They have a job service here, but nothing seems to come up for anybody. As for getting my own place, high rent is the biggest problem. And now there's no limit on how much the landlord can raise the rent. That really messes us up. They should make more low rental housing. A rent subsidy would help so much, but I don't think that's ever going to happen. Do I feel optimistic? No, I don't. Not at all.



Innovative programs reach more clients

MANY PEOPLE WHO LACK HOUSING CAN'T ACCESS BASIC medical and psychiatric services or housing options. In response, some programs are taking innovative approaches in providing help to people on their terms.

"Shelters and hostels have become the refuge for people who are not tolerated elsewhere," says Cynthia Karlton of the Centre for Addiction and Mental Health. Some can't access services because they don't have the necessary papers, while a few aren't eligible. In many cases, people may fear taking medications that they've reacted badly to, or dread being hospitalized.

As a result, Karlton has developed an innovative program with multi-disciplinary teams delivering medical, psychiatric and psychosocial services at sites where people congregate — shelters, hostels and detox centres around the city.

The focus is on bringing medical care directly to people in need. And the aim is to offer this care in the least intrusive, most respectful manner possible, placing as few demands or expectations as possible on recipients.

The program developed last July as a partnership between Toronto Hospital and the Centre. Its shared care outreach teams include full-time clinical outreach workers and nurses, as well as family physicians and part-time psychiatrists who are on salary rather than fee-for-service. Psychiatrists act as consultants to the team, meeting directly with clients only if a psychiatric assessment or medication review is required.

"While this kind of consultation service is widely used in underserved areas like the north, it has never before been brought to the homeless population," says Karlton. She estimates that each staff person can reach about 15 people per day, substantially more than through a traditional approach.

While medical care is important, so is the environment where people seek help. Savard's, a facility for 15 women, is what staff refer to as "a model of unconditional housing." It offers a high level of support, with two staff at all times, health care services and a non-interventionist approach. There are no rules, except to abstain from alcohol and other drug use and violence, and few demands: no specific meal time, no chores, no curfews and no mandatory counselling or organized activities.

Over the last two decades, while use of hostel beds in Toronto has increased three-fold, use by single women and women with children has increased 10 times — in part because people are staying at hostels longer. Places like Savard's become a critical component of the system of care.

Street City and Strachan House, renovated warehouses accommodating 140 people, provide a longer-term housing alternative operating on a harm reduction model.

Residents enter through a two-week hostel program, and can then apply to stay longer in private rooms with shared kitchen and bathroom. Through "town council" meetings, residents provide input on daily operations, selection of new residents, as well as maintenance and safety. A van provide needles exchange nightly, while a health bus offers weekly medical care.

Staff are available 24-hours a day for crisis intervention, informal counselling and emergency referrals, says community housing worker Edie Fisher. Many residents have substance problems, while a few are HIV-positive.

The Annex Harm Reduction Program, part of Seaton House shelter, is unlike almost any other shelter in North America in that it permits residents to drink.

"Chronic drinkers need to drink," says assistant hostel supervisor Jordan Lewis. Anywhere else, they would get barred, kicked out or referred elsewhere. And for some, that means dying on the street.

The Annex approach will be applied to a working farm, which will become home for about 20 to 30 residents next year, Lewis says. The men "will get out of the spiral of an urban lifestyle." They'll live in a rural setting, and may contribute to growing produce, he says.

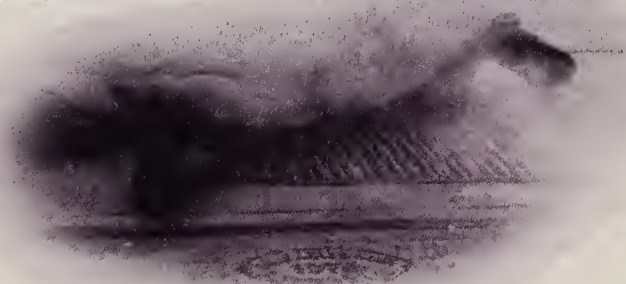
Seaton House's new palliative care program enables residents to die in the shelter among friends, rather than in the anonymity of a hospital room. This is the only program of its kind in the western hemisphere, Lewis says.

One who benefited was Pete, a 56-year-old man brought in off the city's grates.

"He was so blindly drunk they had to carry him inside," Lewis says. Pete lasted about six months, until succumbing to liver cirrhosis. But he died accompanied by friends. About two days before his death, four residents gathered around his bed while a priest performed last rites. In his final days, the men were always around, holding his hand, getting him what he needed.

After living on the street since he was 14, Pete finally died at home.

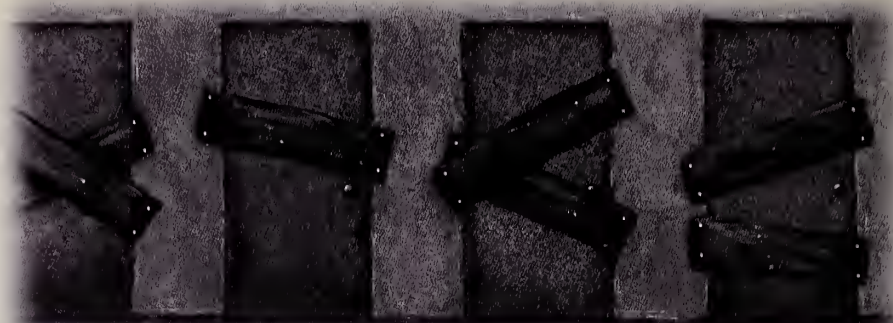
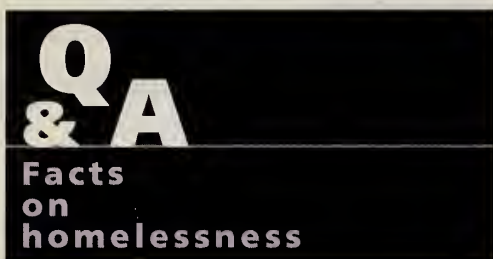
DIANA BALLON



Rev. Barry Fellingner - program co-ordinator, Mission Services of London

I work out of the Men's Mission shelter in London, supervising staff and outreach workers and co-ordinating a life-skills program for psychiatric residents. Our clients struggle with many problems. There are gaps in services due to pressure on the system. There's not enough affordable and accessible housing and our women's shelter, for example, is running at 115 per cent capacity. Probably two thirds or more of the folks we're seeing have concurrent disorders. We also see their ages dropping and see some teenagers who already have a psychiatric diagnosis. The answers? Certainly affordable housing. They have to make more and probably come up with an income or transitional income so a person can afford what exists. Another downfall in the system is if people do get a job, their benefits get cut back. Their drug card goes, their dental card goes. And when it comes to psychiatric needs, that medication is extremely expensive. It would be helpful if those benefits were continued if the job isn't enough. I also think there needs to be more community supports in place, especially with psych hospitals closing. We already have an overflow situation and we must address what we anticipate in the future.

— As told to Cindy McGlynn



How many people in Canada do not have adequate housing? Some estimates suggest that 200,000 people across the country do not have permanent, secure shelter. Many more are in a vulnerable situation. In Toronto, on any given night, 3,000 people stay in a shelter and more than 42,000 are on a waiting list for subsidized housing. An additional 40,000 people are at risk, as they spend more than half their income on housing, according to the Interim Report of the Mayor's Homelessness Action Task Force.

How many among those without housing have a mental health or addiction problem? The Pathways to Homelessness study, conducted by researchers at the Centre for Addiction and Mental Health, interviewed 300 shelter users in Toronto. About 20 per cent had a current substance abuse problem and 20 per cent had a mental illness. About 30 per cent had both.

The most common lifetime mental health diagnosis was a mood disorder, affecting about 38 per cent of the sample. Seven per cent had post-traumatic stress disorder, while five per cent had a psychotic disorder.

What role do mental health or addiction problems play in the loss of housing?

In the Pathways study, only four per cent said their mental illness was the main cause. Eighteen per cent said they lost their homes because of a substance problem, which also was a factor in perpetuating their situation. Many supportive housing programs and shelters exclude people with substance problems.

Six per cent had been in a psychiatric inpatient unit in the past year. There was some evidence of a need for better discharge planning, but the numbers do not fit a common assumption that many people become homeless after being released from hospitals.

People generally lost their homes because they lost their jobs or could not afford to pay rent. The second most common reason was because of divorce or relationship problems. More than 60 per cent cited one of these two reasons.

What are some characteristics of this population? Children made up almost 20 per cent of the homeless population in Toronto, the mayor's task force report found. Aboriginal people comprised about 25 per cent of the population, but

only three per cent of the total population of the city.

Almost half of the shelter users in Toronto came from outside the city.

About 38 per cent of the people interviewed in the Pathways study had no source of income. People in the shelter system are usually not allowed to receive welfare or family benefits.

How did the situation become a crisis?

An analogy that's been used is that housing instability is like a game of "musical chairs." The number of chairs — affordable housing — has been shrinking over the past few years, affected by factors such as cuts to welfare and funding for non-profit housing.

Three-quarters of people are using shelters chronically or as permanent housing, according to the mayor's task force report.

As the "chairs" become scarce, and emergency shelters begin to be used as permanent housing, the number of people who are literally left out in the cold increases, as do problems associated with homelessness.

People without housing, not surprisingly, are more likely to become depressed or develop a substance problem, and their overall physical health will suffer. The rate of mental illness in the Pathways study was two to three times higher than the general population, and substance abuse four to five times higher. Many reported chronic health problems and injuries, but more spent time in jails or police stations than in a medical facility over the past year.

What is needed as a long-term solution, particularly for people with serious mental health or addiction issues?

Experts and research both suggest that client-centred, multi-disciplinary, comprehensive services including outreach, case management, flexible mental health and addiction treatment and a range of housing options is needed.

In terms of hard numbers, Toronto alone immediately needs 5,000 extra units of supportive housing for chronic shelter users, according to the task force. Supportive housing could include subsidized housing plus services, group homes, supervised apartments, or housing with mobile community supports.

The task force also calls for supportive housing for people with addictions, who are often ineligible because of their substance use.

How well are emergency shelters equipped to help people with a mental health or addiction problem? It depends on the service. Some, as in the programs described on page 13, take innovative approaches and make few demands on their clients. Many agencies provide referrals, needle exchanges, help seeking housing and employment assistance. Others may disqualify clients who show signs of addiction or mental illness.

How are services funded? Dedicated supportive housing is funded in part by the Ministries of Health and Community and Social Services, as well as municipalities or non-profit agencies. In Ontario, emergency shelters are funded 80 per cent by the province and 20 per cent locally. The same applies to "domiciliary hostels," which are usually for-profit, permanent housing, often for people with mental health problems or the elderly. The federal government ended its funding for public housing in 1993, followed by the Ontario government in 1995.

What approach does the U.S. take?

The U.S. federal government provides strong policy direction and some funding for homelessness programs, with municipalities tailoring services to suit their needs. In October, Congress increased funding for rental assistance for people with disabilities, including severe mental illnesses, and for programs under the McKinney Homeless Assistance Act of 1987. This act, created to provide a more co-ordinated approach to services, delivered grants to research innovative projects, required states and municipalities to prepare comprehensive homeless assistance plans, and established mental health services programs for people lacking permanent housing.

Congress also passed the Quality Housing Work Responsibility Act. It requires the health, labor and housing departments to develop an action plan to guide communities on how to improve treatment services for residents of public and assisted housing, and to disseminate a "best practices" guide. ■

Sources:

Mental Illness and Pathways into Homelessness; Breaking the Cycle of Homelessness - Interim Report of the Mayor's Homelessness Action Task Force; Report of the Provincial Task Force on Homelessness; NAMI Enews; Access (newsletter of the U.S. National Resource Centre on Homelessness and Mental Illness).

Health at work

"Most people know the price of everything and the value of nothing." Oscar Wilde's aphorism may be a very serviceable definition of post-industrial western society at the turn of the millennium. A society where the social safety net has been shredded by the economic dogma of "unleashed" market forces and globalization. A consequence of this is a workplace culture of "more with less" that translates not only to "more work, less pay" but more work, more stress, less staff, less security, resulting in less health.

But business is about producing — so isn't employee health a secondary consideration? Well, no. Both very much depend on each other.

Mindsets — Mental Health: the ultimate productivity weapon takes the familiar approach, long used by Employee Assistance advocates, that employee well-being is a bottom line issue. It argues that some people in the workplace are

going to be less equipped to deal with these new stresses than others. How big is the problem? Massive — a quarter of a billion people worldwide, and 30 to 40 million women in North America, suffer from depression alone. It robs more people of productive working years than cancer, heart disease, AIDs or war. Sadly, 80 per cent of cases remain undiagnosed and untreated. The cost runs into billions annually.

This year, with the formation of the Canadian Business and Economic Roundtable on Mental Health, an attempt is being made to define mental health as a business issue. The roundtable is an alliance of business executives, psychiatrists, researchers, physicians, psychologists and health educators developing an agenda for effective action. *Mindsets*, co-written by president Bill Wilkerson, is a commentary on the scope of the problem, its impact on the economy, the powerful link between mental health and heart disease and

much more. The concept of using the workplace as an opportunity to help troubled workers overcome their denial, get diagnosed and seek help is in everyone's interest — companies, unions, individuals and the state — although perhaps for different reasons.

The authors *want* the issue to be driven by the bottom line as this allows employers to buy into the concept of a healthy workplace without compromising business goals. *Mindsets* is an important and timely book. As an overview of the negative impact of the blinding pace of change in the workplace and paradoxically, of the opportunities for improved health that this change affords, the book is excellent. Its "from the ground up" approach places the issue in context and argues for the attention it deserves. **ARTHUR MCCUDDEN**

Mindsets - Mental Health: the Ultimate Productivity Weapon, Edgardo Perez, MD & Bill Wilkerson, The Homewood Centre for Organizational Health at Riverslea, 1998, 358pp.

Evil or ill?

Manson, Bernardo, Dahmer, Hinckley, Bobbitt. Names even casual news browsers connect with insanity — or pleas of such. But were they ill? Or profoundly bad? Or were they sick as well as wicked?

While the title, *Evil or Ill? Justifying the Insanity Defence*, suggests the two positions are mutually exclusive, University of Toronto psychiatry professor Lawrie Reznick maintains that, in fact, they are not. "Illness," he says, "does not imply the absence of evil." Some people, unfortunately, are both.

So how does a jury determine who's to blame and who's NGRI, not guilty by reason of insanity? Mostly, says Reznick, it's a judgment about character. "It is the notion of evil character (and not evil intent) that best explains why we accept the excuses we do... Justice

requires that we only punish evil characters, and thus we should excuse the good person who acted out of character." It basically comes down to one question for a jury: 'If we take away the disease, do we have a good character?'

And it's the jury, not the medical expert, who is best able to determine that because, he believes, "insanity is a moral notion, and thus not something a psychiatrist is specially qualified to assess."

Reznick states that this book is about excuses in general and the insanity defence in particular. Understanding the nature of excuses is crucial to coming to any conclusion about who is evil and deserves punishment, and who is mentally ill and merits treatment.

To the traditional excuses of ignorance and compulsion, Reznick adds a third: the excuse of character change — 'I'm not guilty because I wasn't myself when I committed the offence.' This, he says, is the pivotal one that demonstrates "what is at the centre of all excuses — the need to punish evil characters and protect society from them."

People instinctively know this, Reznick argues, which is why folk psychology, assuming as it does that intentional behavior is guided by desires and beliefs and that people are rational enough to be responsible, is — and should be — the standard we use to establish guilt or NGRI.

So, says Reznick, it is up to the people. And they are usually right. Sexual sadists Manson, Bernardo and Dahmer were judged guilty by their peers. Bobbitt, who cut off her husband's penis after he raped her, and Hinckley, the would-be assassin of Ronald Reagan, were

found NGRI, although Reznick regards the latter decision a mistake.

While *Evil or Ill?* should interest anyone facing jury duty, they're in for a complicated read. It will likely be those schooled in psychiatry or law who will most appreciate Reznick's keen, philosophically-trained mind. **BARBARA FULTON**

Evil or Ill? Justifying the Insanity Defence, Lawrie Reznick, MD, Routledge, New York, 1997, 329 pp.

Also Noted...

Alcohol: Opposing Viewpoints

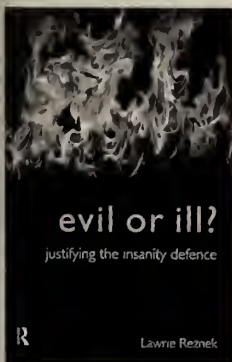
Gravenhurst Series, San Diego, California, 1998.

In different chapters, experts argue for and against issues such as the benefits of moderate drinking, the effect of television advertising on underage drinking, whether alcoholism is a disease or not, the effectiveness of AA, and the impact of raising alcohol taxes.

Nicotine Safety and Toxicity

Ed. Neal L. Benowitz, Oxford University Press, 1998.

Experts review the toxic effects of nicotine on the body in the context of different conditions, including cancer, reproduction and long-term nicotine therapy. The book also considers the risks and benefits of nicotine as a treatment for health disorders, including ulcerative colitis and Tourette syndrome.



The Last Word

We welcome submissions from our readers for opinion pieces. For information, contact the Editor, *Journal of Addiction and Mental Health*, 33 Russell St., Toronto, ON M5S 2S1, tel (416) 595-6714, email <adubey@arf.org>.

No quick **fix**

But we can improve mental health services

BY SCOTT SIMMIE

Condensed from a speech delivered for the Mood Disorders Association of Ontario and Toronto. Simmie's "Out of Mind" series, which he wrote as an Atkinson Fellow, first appeared in the Toronto Star. Copies are available at (416) 368-5152.

THE DELIVERY OF MENTAL HEALTH SERVICES IS A COMPLEX task, requiring — as one doctor described it — a cafeteria of options. But the desired menu varies widely, depending on who's talking. Everyone wants something. Transitional funding. Mental health authorities. Bigger hospitals. Fewer hospitals. No hospitals. Transit tokens. Everyone agrees, however, that is one thing needed. Action.

The following solutions would go a long way to addressing key problems:

Transitional Dollars - The Provincial Advisory Committee estimates that \$400 million is required to provide adequate supports prior to closing provincial psychiatric hospitals. So far, roughly \$60 million has been announced. I've been told local mental health and addiction agencies have yet to see any of it. British Columbia, which had to reassess its reform process in 1996, has this advice for Ontario. "You cannot take beds out of a provincial psychiatric hospital without adequately replacing those beds in the community first," says John Fox of BC's Riverview Hospital. "That's why our downsizing stopped in 1996. It wasn't working."

Housing - Developing housing makes economic sense. Many people living in psychiatric hospitals could do quite well with adequate community supports. The cost of a single long-term bed can run above \$15,000 per month. The cost of a self-contained room in housing with mental health supports is about \$1,000 per month. Countless studies have shown that quality housing, in conjunction with supports, is highly effective in lowering readmission rates.

Forensics - Specialized housing is crucial. The number of people with mental disorders who have come into conflict with the law, sometimes for minor offences, has grown an average of 10 per cent per year since 1992. At last count, 22 per cent of the general civil beds at the Queen Street division of the Centre for Addiction and Mental Health were occupied by Ontario Review Board patients. Freeing some of those beds increases the likelihood that someone in crisis will gain admission — and not deteriorate in the community to the point of becoming a forensic patient. In one case, the "system" was able to spend at least \$170,000 to keep one man in jail or hospital for the offences of picking up a broom and spitting on someone. That money could have kept him in supportive housing for at least *sixteen* years.

Community Treatment Orders (CTOs) - The Ontario Ministry of Health is considering this contentious legislation. Such orders would legally bind certain individuals with severe mental illness to take their medication. Failure to comply would be grounds to return the person to hospital for examination. The danger of CTOs is that they may prove a convenient "fix" in what should be an era of thoughtful planning. Medication is not the sole determinant of mental health. Some people suffer relapses because of poor housing and constant isolation. Some people deliberately stop taking their medication because they find psychosis preferable to their

reality. There can be no more damning a condemnation of the way we treat those with mental health problems than this.

Atypical Medications - Some of the newer medications used to treat schizophrenia have shown remarkable results. Yet a person covered by the Ontario Drug Benefits Plan cannot access the newer medications unless they fail to respond to, or suffer severe side effects from, the older medications. The difference is a dollars and cents issue. A 10mg tablet of olanzapine (Zyprexa) costs \$6.75. A 10mg tablet of haloperidol (Haldol - an older anti-psychotic, which often produces severe side-effects) costs \$0.13. If a person stops taking their Haldol, because they feel it deadens them, their condition deteriorates and they wind up in hospital, it'll cost about \$500 a day. That buys a lot of olanzapine.

Children - Children must become a major priority. An initiative aimed at "defragmenting" child and adolescent mental health services is underway. Dr. Bruce Ferguson, on the topic of children at risk for developing mental health problems, told a conference that "being on welfare played a special role above and beyond all other factors. Twenty-one per cent of our children are living in poverty."

Crisis Support - Toronto's Gerstein Centre is a non-medical safe house. It is a place where people in crisis can find refuge, support and respite. More facilities based on this model are needed. Also, the Ministry of Health should have a 24-hour information/crisis line devoted to mental health, staffed by trained consumer/survivors. This would not only provide callers with the information they need, it would provide consumer/survivors with something they need. Jobs.

Alternative Businesses - People with mental health problems face tremendous barriers to the workplace. The biggest, for many, is not their mental health. It is poverty. A bright spot is the Ministry of Health's subsidization of Alternative Businesses, which employ people who have experienced mental health problems. A study showed that those involved reduced their rehospitalization to one-tenth its previous rate. Having a place to go, a job to perform and meaningful human contact is a clear determinant of mental health. These programs should expand.

Anti-stigma Campaign - Stigma is huge. It throws up barriers to employment, to housing, to integration, even to treatment. Myths surrounding the mentally ill must be replaced by facts, including the fact that between one in five and one in eight Canadians will develop a mental health problem requiring intervention. Such a campaign should have the imprint and authority of the Ministry of Health or Health Canada.

The creation of a true mental health system requires vision. It requires political will. It requires money. There exists now, given the recommendations of the Health Services Restructuring Commission, an historic opportunity to put things right.

Whether it's a friend, a colleague, or someone living in a bus shelter, there are really only eight kinds of people affected by mental health problems. Someone's mother, daughter, sister or wife; someone's father, husband, brother or son.

People. Like you. And like me. ■



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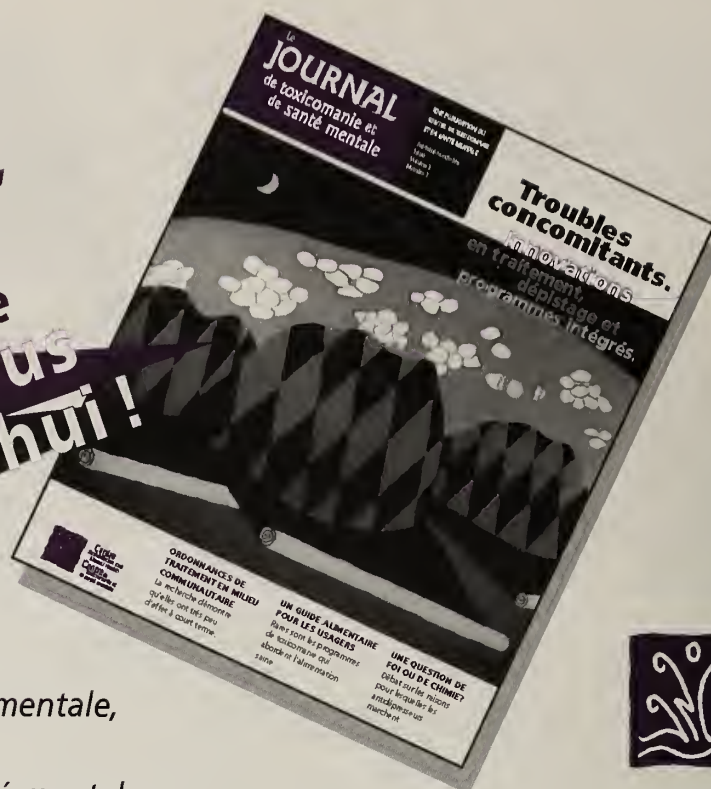
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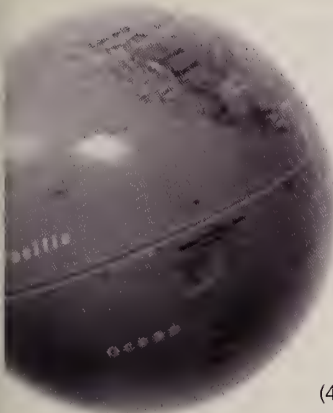


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M9B 4B1, tel (416) 622-8833,
fax (416) 622-7068.

Women and Psychosis

Feb. 25-26, 1999, Toronto,
Ontario. Contact: Centre for
Addiction and Mental Health,

Alternatives to Attention Deficit Disorder-Children are First Training Series

April 22-23, 1999, Toronto,
Ontario. Contact: Brief
Therapy Training Centres-
International, 114 Maitland
St., Toronto, ON M4Y 1E1,
tel (416) 972-1935, ext. 3345,
fax (416) 924-9808; email
<hincks@interlog.com>.

Interprovincial Conference on Fetal Alcohol Syndrome

May 4-7, 1999, Calgary,
Alberta. Contact: Lyne Callan,
Conference Program
Committee, AADAC Training
and Communications Services,
3rd flr, Stephenson Building,
1177-11 Avenue S.W.,
Calgary, Alberta T2R 0G5,
tel (403) 297-3019, fax
(403) 297-3020, email
<lyne-callan@aadac.gov.ab.ca>.

International Conference on FAS/FAE: Uncovering the Mysteries of Fetal Alcohol Syndrome: Is There Hope?

May 5-7, 1999, Lethbridge,
Alberta. Contact: Tamara D.
Hanoski, Family Care, Ltd.,
1256 3rd Ave. S., Lethbridge,
Alberta T1J 0J9, tel (403)
320-1399, fax (403) 327-6337.

AIDS Impact 1999 - Biopsychosocial Aspects of HIV Infection

July 15-18, 1999, Ottawa,
Ontario. Contact: Canadian

Psychological Association,
205-151 Slater St.,
Ottawa, ON K1P 5H3,
tel (613) 237-2144,
fax (613) 237-1674,
web <www.aidsimpact.com>.

UNITED STATES

10th Annual Meeting: Partnership with Business - Enhancing Mental Health in the Workplace

Jan. 15-17, 1999, Washington
DC. Contact: Academy
of Organizational and
Occupational Psychiatry,
12200 Preston Rd., Dallas,
TX 75230, tel (214) 392-0552.

Prevention Think Tank Symposion

Jan. 21-24, 1999, Singers
Island, Florida. Contact:
Prevention Think Tank,
Barbara Jacobi, P.O. Box 5941,
Bethesda, MD 20824,

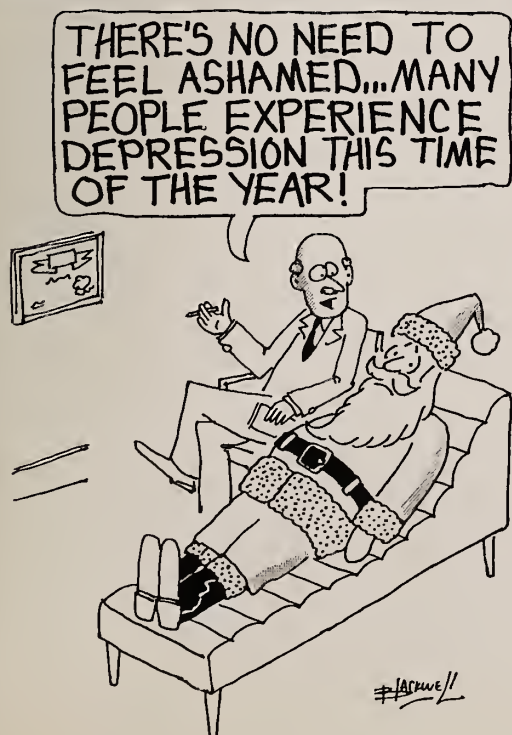
tel (301) 518-2354, e-mail
<bajacobi@erols.com>, web
<www.jacobi-assoc.com/
prevthink/symplosion.html>.

Treatment of Addictive Disorders

Jan. 25-29, 1999, Colorado
Springs, Colorado. Contact:
Gary Forrest, 3208 N.
Academy Blvd., Colorado
Springs, CO 80917,
tel (719) 594-9304,
fax (719) 597-0166.

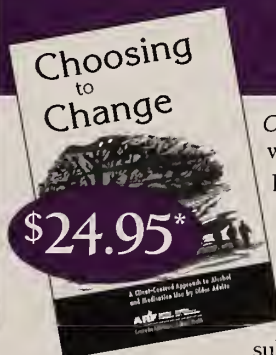
Reclaiming Our Youth: Building Bridges for the 21st Century - Tenth Annual Youth-At-Risk Conference

Feb. 28-March 2, 1999,
Savannah, Georgia. Contact:
Division of Continuing
Education, Georgia Southern
University, P.O. Box 8124,
Statesboro, GA 30460-8124,
tel (912) 681-5555,
fax (912) 681-0306, email
<sfickle@gsaix2.cc.gasou.edu>.



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American Psychosomatic Society 57th Annual Scientific Meeting

March 17-20, 1999, Vancouver, BC. Contact: The American Psychosomatic Society, 6728 Old McLean Village Dr., McLean, VA 22101-3906, tel (703) 556-9222, email <info@psychosomatic.org>.

Women and Children in Treatment

April 23-24, 1999, Sarasota, Florida. Contact: National Acupuncture Detoxification Treatment, 3220 N Street NW #275, Washington DC 20007, fax (805) 969-6501, email <AcuDetox@aol.com>.

30th Annual Medical Scientific Conference

April 29-May 2, 1999. Contact: American Society of Addiction Medicine, 4601 N. Park Ave., Upper Arcade #101, Chevy Chase, MD 20815-4520, tel (301) 656-3920, web <www.asam.org>.

ABROAD

Natural History of Addictions: Recovery from Alcohol, Tobacco and Other Drug Problems Without Treatment

March 7-12, 1999, Les Diablerets, Switzerland. Contact: Harald Klingemann, Swiss Institute for the Prevention of Alcohol and Other Drug Problems (SIPA), C.P. 870, CH-1001 Lausanne, Switzerland, tel 41 21 321 295 5, fax 41 21 321 29 40; email <hklingemann@sfa-isp.ch>.

Canadian Psychiatric Association (CPA) 4th International Conference

March 15-19, 1999, Puerto Vallarta, Mexico. Contact: CPA, 260-441 MacLaren St., Ottawa, ON J0X 1G0, tel (613)

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10th International Conference on the Reduction of Drug-Related Harm

March 21-25, 1999, Geneva, Switzerland. Contact: HIT Conferences, Cavern Walks, 8 Mathew St., Liverpool L2 6RE, email <hrc@hit.demon.co.uk>, web <www.ihra.org.uk/geneve>.

Australasian Conference on Drugs Strategy

April 27-29, 1999, Adelaide, Australia. Contact: Drugs Strategy Secretariat, S.A. Police, GPO Box 1539 Adelaide SA 5001, Australia, tel. 011 61 08 8204 2820, e-mail <dap@camtech.net.au>.

College on Problems of Drug Dependence

June 12-17, 1999, Acapulco, Mexico. Call for abstracts on

Women, Gender and Drug Abuse Research. Contact: Dr. Martin W. Adler, Dept. of Pharmacology, Temple University School of Medicine, 3420 N. Broad St., Philadelphia, PA 19140, fax (215) 707-1904.

XXVII International Congress of Psychology

July 23-28, 2000, Stockholm, Sweden. Contact: Stockholm Convention Bureau, Box 6911,

S-102 39 Stockholm, Sweden, fax 46 8 34 84 41, email <icp2000@stocon.se>.

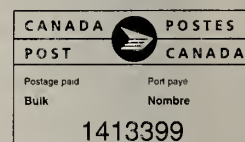
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AND MENTAL HEALTH

January/February
1999
Volume 2
Number 1

treatment vs. punishment

addictions, mental health and crime



NEW APPROACHES TO TRAUMA THERAPY

Focus on women's
strengths, not symptoms

TEEN GAMBLING ON THE INCREASE

A challenge for
prevention programs

TREATING MOOD DISORDERS

Experts present
a different model

PERIODICALS READING ROOM
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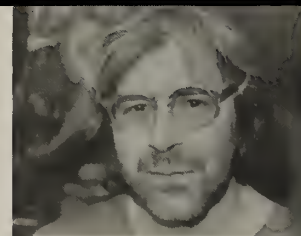
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Cover

"The Scott Mission"
by Alan Parker
oil on canvas

"This painting is based
on the work of the
German expressionist painters, and their social commentary of
the 20s and 30s," says Toronto artist Alan Parker. "I eat at the
Scott Mission, and the feeling I get from this painting is one of
comradeship through adversity. The Scott is like that.

"I've been painting seriously since 1980, apart from lapses
in my life, because of the nature of my illness."



News from the Centre

IN EARLY DECEMBER, THE CENTRE HOSTED a media conference at which the Ontario Ministry of Health announced funding for 30 forensic beds at the Centre's Queen Street site. In total, the Minister announced approximately \$21 million in services for the Toronto area, including support for Assertive Community Treatment Teams, case management services and forensic services. This announcement is part of \$60 million announced earlier in the year. Jean Simpson, Executive Vice President and Chief Operating Officer of the Centre said that although she was pleased to see the government's support in the forensic area, additional resources are required to address anticipated pressures for general forensic beds, based on current trends. The number of forensic patients in Ontario has increased on average by approximately 10 per cent each year. In addition, an increased number of medium secure beds is needed to address waiting list pressures and needs of specialized sub-groups including women and "residential" programming.

These new beds will help to support the increasing demand for forensic services in Ontario, and the Centre has been working to integrate and expand its forensic services to meet the growing need. Last fall, the Centre created a 32-member steering committee which included among others, representatives from forensic programs at the Centre, the Ministry of Health, the University of

Toronto, Correctional Services, the community, forensic patients and their families, and the judicial system to plan integration of the Centre's forensic services. As part of the planning process, the Committee also established task forces to examine key areas including the needs of mentally disordered offenders and their families; community reintegration; and forensic psychiatric services within the criminal justice system. The plan is anticipated to be submitted to senior management later this winter.

Also in early December, Canada's first drug treatment court opened in Toronto. The court is a pilot project designed to divert offenders from jail and into a program that could reduce both repeat offenders and the harm caused by drugs. The Centre is providing the treatment component of the project. The Centre has been working with a number of community organizations in the development of this project which will receive \$1.6 million over four years from the federal National Crime Prevention Centre.

In an area that is attracting increasing interest, the Centre has approved a scientific trial in North America of prescribing heroin to people who have tried other treatment approaches and failed, or who cannot be attracted into other programs. The Centre will be working with international partners to draft the protocols and implement the research project.



Letters

A pleasure to read

It was with great pleasure that I read the first two issues of *The Journal of Addiction and Mental Health*.

In my opinion, it is a high quality publication. I appreciate the format, the visual presentation and the quality of the content. It is first-rank work for all addiction and mental health professionals in Ontario. As a francophone, I particularly appreciate the fact that all the articles are translated into a high quality French.

I wish a long life to *The Journal*.

Robert Laviolette

Director, adult treatment centre
Maison Fraternité
Vanier, Ontario

Letters to the editor are welcome. They must be signed and include a daytime telephone number. Letters may be edited to fit space.

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<Downloaded>

"The original goals for drug courts – reduction in recidivism and drug usage – are being achieved, with recidivism rates substantially reduced for graduates, and to a lesser but significant degree, for participants who do not graduate as well."

From the report,

"Looking at a Decade of Drug Courts"

From:

U.S. Department of Justice, Drug Courts
Program Office:

www.ojp.usdoj.gov/decade98.htm

This report summarizes evaluative information on drug court programs throughout the United States, going into such details as cost savings, recidivism statistics, participant characteristics and services provided.

Bureau of Justice Statistics:

www.ojp.usdoj.gov/bjs/crimoff.htm

This site includes figures on characteristics of prison inmates. Statistics show that more than one third of jail inmates reported a physical or mental disability, and one fifth were held for a drug crime.

Federal Bureau of Investigation (FBI):

www.fbi.gov

The FBI Uniform Crime Report, released in November 1998, shows that marijuana arrests were higher in 1997 than any other year. Of the 695,201 arrests, 87 per cent were for possession. This number was almost as high as arrests for murder, rape, robbery and aggravated assault combined. Look under news, press releases, for a copy of the report.

SHEILA LACROIX

In Brief



Bans don't hurt business

Restaurant smoking bans in New York City and Massachusetts have not had an impact on sales, according to studies published in the January *Journal of Public Health Management and Practice* (vol. 5, no. 1). The studies looked at taxable sales receipts. Since 1995, sales have risen two per cent in New York, and four per cent in cities in Massachusetts with bans. Although some smokers reported dining out less frequently, non-smokers ate out more often.

Y2K and anxiety

Some experts are predicting that the Year 2000 computer problem will cause problems for a sub-group of patients with anxiety-related disorders, reports the *Monitor* of the American Psychological Association (vol. 30, no. 1). These fears arise through the unpredictability of what will happen once computer systems' dates switch to "00." Doomsayers are forecasting disaster, suggesting people convert their cash to gold and stockpile food. Experts, who have already seen cases of patients expressing fears, advise counselling people to question both their own assumptions and where the information is coming from.

Teen drug use stabilizes

Drug use among U.S. teenagers has stabilized and for some substances, has dropped slightly, after six years of increases. The 1998 *Monitoring the Future* surveyed almost 50,000 students. About 22 per cent of Grade 8s, and 41 per cent of Grade 12s reported using any illicit drug during the past three months. In the previous month, 17 per cent of 8th graders

and 38 per cent of 12th graders had smoked marijuana. Among Grade 12 students, 22 per cent smoke daily and 33 per cent said they had been drunk at least once in the past 30 days. The study is available at <www.isr.umich.edu/src/mtf>.

Combination therapy helps

A combination of therapy and medication is more effective at preventing relapse of depression in elderly patients than either option alone, a new study suggests. After three years, 80 per cent of the group receiving both the antidepressant nortriptyline and interpersonal therapy did not relapse. Of those who received the drug only, 57 per cent remained well, compared to 36 per cent of the therapy-only group. Just 10 per cent of the placebo group did not relapse. A total of 124 people aged 60 and older participated in the study out of the University of Pittsburgh. Results are in the *Journal of the American Medical Association* (vol. 281).

Quality care for women

A new health council has been formed to ensure the Ontario health care system responds to women's needs, while the British Columbia Centre of Excellence for Women's Health is supporting research to analyze the impact of mental health reform on women. The Ontario council will act in an advisory role to the Minister of Health. The B.C. project aims to develop a framework for women-centred mental health care for use in other provinces. Details are available on the Ontario council at <www.gov.on.ca/health> and on the B.C. research at <www.bccewh.bc.ca>.

Disability and addiction

An expert panel has released guidelines on providing effective treatments for people with disabilities and addictions, a group at high risk of developing substance abuse problems. Statistics from New York state show that 22 per cent of clients treated at licenced facilities in 1997 had a physical or mental disability. The consensus panel, convened by the U.S. Centre for Substance Abuse Treatment, developed the guidelines to help professionals with little experience in the area, so that they can identify barriers and accommodate those with disabilities. The protocol is available at

<www.samsha.gov> or at 1-800-729-6686 or TDD 1-800-487-4889.

"Happy patch" tested

A pharmaceutical company in Florida is developing a skin patch that would deliver antidepressants directly to the bloodstream. The transdermal delivery system, or "happy patch" is being tested with the drug selegiline (El-depryl), reports the *National Post*. As a class of monoamine oxidase inhibitor, selegiline is an effective treatment for depression, but one side effect is that it interferes with the body's ability to digest certain foods. The patch system bypasses the digestive process. Clinical trials are underway in six U.S. cities, headed by Harvard psychiatrist Dr. Alexander Bodkin.

Study of consumer support

A new study is examining how stronger community supports, including help from peers, will improve the quality of life for patients being discharged from psychiatric hospitals. The three-year study, headed by researchers at the University of Western Ontario, will involve 540 patients from London, Hamilton and Whitby hospitals. Each patient will be paired with a consumer successfully living in the community, and will stay involved with hospital staff until they develop relationships with community service providers. Hospital care currently accounts for 80 per cent of mental health funding, but the government wants to reduce this to 40 per cent. The lead researcher is Dr. Cheryl Forchuk at (519) 685-8500 ext. 77034.

Dangers of ultra-rapid detox

The risks associated with ultra-rapid opiate detoxification outweigh its benefits, notes an editorial in *Addiction* (vol. 93, no. 11). The URD technique places opiate addicts under anesthesia and then provides various drugs that aid in withdrawal. The article notes that at least four deaths have occurred linked to the procedure, although precise causes are not known. It also points out that since detoxification is not a cure for addiction, and success rates are not known, it is difficult to justify such a potentially risky and expensive procedure. The author also acknowledges URD's potential benefits, such as its appeal to those who fear going through withdrawal.

Better treatments for schizophrenia

ALTHOUGH PEOPLE WITH SCHIZOPHRENIA have relatively successful treatment results, there is a need and an opportunity to improve outcomes for what one researcher calls “arguably the most significant of the world’s health problems.”

In 60 per cent of cases, treatment for schizophrenia leads to good results, according to a survey of 1,100 articles carried out by Dr. Samuel J. Keith and colleagues at the University of New Mexico School of Medicine. Dr. Keith spoke at a symposium, *Overcoming Barriers in Managing Schizophrenia: Practical Approaches*, held in December at the Centre for Addiction and Mental Health.

In comparison, a study in the *New England Journal of Medicine* looking at two treatments for heart disease found success rates of 41 and 52 per cent, says Dr. Keith.

Yet between 50 and 75 per cent of people on antipsychotic drugs will stop taking their medication prematurely, says symposium speaker Kimberly

Littrell, president of the Promedica Research Centre in Tucker, Georgia.

Part of the reason is severe side effects. “The illness is bad enough that we don’t need treatments that make it worse,” says Dr. Keith. He considers schizophrenia one of the world’s most serious health problems since it primarily affects young people under the age of 25.

This is where the new atypical medications hold promise. To the same or a greater degree as standard medications, the atypicals reduce the “positive” symptoms of schizophrenia — the hallucinations, delusions and disorganized thought. Where the new medications differ is in their impact on improving the “negative” symptoms — the inability to show emotions, process speech fluently or experience pleasure. They also lead to fewer extrapyramidal symptoms such as restlessness, tremors, stiffness, muscle cramping and contortions.

Still, simply prescribing new medications will not ensure better results, partly because they have side effects also. Most notably, weight gain associated with olanzapine and clozapine can put patients at risk of cardiovascular disease or diabetes, says Dr. Keith. One study found 41 per cent of patients on olanzapine, compared to three per cent with placebo and 12 per cent with

the standard haloperidol will gain seven per cent of their body weight. Risperidone, like older drugs, is linked with increases in prolactin, possibly leading to irregular menstruation.

Clinicians must openly discuss side effects with patients, and develop strategies to deal with these problems, such as exercise and diet for the weight gain, says Littrell.

Apart from side effects, other factors may prevent patients from adhering to treatment, she says. The illness itself may lead to clouded judgment or denial, and their relationships with treatment providers also has an effect.

“Clinicians should routinely query patients about their use of medications, problems with compliance and ways to improve compliance, and also about their feelings associated with continued medication use,” says Littrell. While the patient is lucid, both therapists and patients should identify a plan of action to aid in compliance. Educating the patient’s family or caregiver is essential, she adds.

But Littrell notes that relapse sometimes occurs because professionals may not be prescribing appropriately. To minimize deviations in practice, there are now treatment guidelines, including the American Psychiatric Association Practice Guidelines, Expert Consensus Guidelines for Schizophrenia and Schizophrenia PORT Recommendations. **ANITA DUBEY**

New guidelines for SAD released

AGROUP OF CLINICIANS AND RESEARCHERS from across Canada has formulated consensus guidelines for the treatment of seasonal affective disorder (SAD). A subtype of major depression, SAD usually occurs in winter. The guidelines will aid clinicians in identifying patients with SAD and in answering questions from patients or family members.

“When this group first met in 1994, there wasn’t enough evidence to formulate specific guidelines,” says Dr. Raymond Lam, co-editor of the report and head of the mood disorders division at the University of British Columbia’s psychiatry department. “Over the past four years, new studies have clearly outlined the diagnostic criteria for SAD and shown that light therapy and antidepressant medications are effective treatments.”

Studies indicate that between two and three per cent of Canadians suffer from seasonal affective disorder. However, many cases go unreported. “Like clinical depression, where only 50 per cent of those affected seek help

or get treatment, many with SAD don’t recognize that they have the disorder,” notes Dr. Lam. “They suffer quietly all winter long, thinking they have flu-like symptoms.”

According to Dr. Lam, there are still misconceptions about the disorder. “First, some mistake [SAD], a form of clinical depression, for nothing more than the winter blahs. And second, there is a tendency to trivialize people’s suffering,” he says.

SAD is characterized by four central features, according to the guidelines:

- recurrent major depressive episodes that start at the same time each year, around September or October, and end at the same time each year, around March or April
- remission of symptoms during the unaffected period of the year
- over the lifetime course of the illness, relatively more seasonal depressive episodes than non-seasonal episodes
- seasonal depressive episodes in at least two consecutive years.

For most people with SAD, symptoms include a prolonged sense of sadness or low mood with profound fatigue, a tendency to oversleep, low concentration levels, and an increased appetite, especially with carbohydrate cravings for potatoes, bread and rice.

The guidelines advise that an effective first line treatment for SAD is light therapy — daily scheduled exposure to bright, artificial light. A fluorescent light box with a light intensity of 10,000 lux is the standard treatment. People who spend 30 minutes correctly positioned in front of the box, preferably early in the morning, will maximize their response to treatment. Improvement generally occurs within two to four days.

For SAD patients with more severe depression, or those who find light therapy inconvenient, antidepressant medications can be used. Studies have shown that sertraline and fluoxetine are effective.

A summary of the guidelines is in the October 1998 *Canadian Journal of Diagnosis*. **GERRY LUCIANO**

A new way to treat mood disorders

PSYCHIATRISTS NEED TO RETHINK THE way they categorize and treat mood disorders, say three experts who have written a book on the subject.

At present, psychiatrists tend to treat mental illness according to the age of the patient. Therefore there are psychiatrists who specialize in treating children and adolescents, others who treat adults and finally geriatric specialists. But the problem is that most psychiatric illnesses can't be compartmentalized by age, says Dr. Stan Kutcher, co-author of *Mood Disorders Across the Life Span* with Dr. Kenneth I. Shulman of Sunnybrook Health Science Centre, and Dr. Mauricio Tohen of Harvard University.

"Because of the nature of psychiatric disorders it confers often a lifelong vulnerability to relapse. If you really want to understand mental illnesses, if you really want to manage [them] you need to take a longitudinal approach," says Dr. Shulman, psychiatrist-in-

chief at Sunnybrook and vice-chair of clinical affairs at the University of Toronto psychiatry department.

The model that they have developed is the equivalent of what is called total risk management in the corporate world. It looks, for example, at the risk factors for a disease and how these factors play out over an individual's life span.

"By examining trends in their development, it may be possible to predict and treat mood disorders more effectively," says Dr. Kutcher, head of the psychiatry department at Dalhousie University in Halifax.

In the case of depression that begins in childhood, the number one risk factor is a positive family history. Not surprisingly, female children of depressed mothers have the highest risk in adulthood of developing depression.

"Therefore," said Dr. Kutcher, "it makes sound medical sense to focus efforts on those

families who have the illness. But you don't do that if you think in silos. Psychiatrists need to move out of their individual silos. But right now nowhere in the country is that systematically being done."

Dr. Schulman says that a person with recurrent episodes of a mood disorder needs to be connected to a psychiatrist or a clinic probably for life to be effectively treated. He adds that it's hard for psychiatrists to have a life-long perspective because of their training and the nature of their practices. A specialist in adolescent psychiatric disorders would only see teenagers, for example.

"The model is relatively new to psychiatry and to medicine," Dr. Kutcher adds. "We have been trained to treat the disease as opposed to the individual and the family. This is true regardless of whether we're treating anxiety disorders, psychotic disorders or mood disorders." **DONALEE MOULTON**

Report card on Canada's drunk driving initiatives

CANADIAN PROGRAMS GEARED TO reduce drinking and driving are working — slowly.

Public awareness campaigns, tougher laws and police spot checks were some measures originally included in the national Strategy to Reduce Impaired Driving (STRID). First introduced in 1990 by the Council of Ministers responsible for transportation and highway safety, the goal of STRID was to reduce by 20 per cent the number of fatalities involving drinking drivers by 1995. It was then renewed to 2001, with expanded recommendations.

The Traffic Injury Research Foundation (TIRF), commissioned by the Canadian Council of Motor Transport Administrators and Transport Canada to monitor the progress of STRID, released a progress report in 1998.

While the report shows small decreases in the number of people injured or killed by drunk drivers, results show that we still have a long way to go before victory can be claimed.

By combining education and public-awareness campaigns with tougher laws, STRID has made some headway. Between 1992 and 1996, for example, the TIRF report found a gradual decline in the number of fatally injured drivers who had been drinking, from 48 per cent in 1992 to 42 per cent in 1996.

The report also found that alcohol involvement in all motor vehicle fatalities decreased by five per cent between 1995 and 1996. Alcohol

involvement in serious injury crashes also declined by five per cent in the same time period.

However, alcohol still accounted for 36 per cent of all motor vehicle fatalities involving a drinking driver in 1996. This translates into an estimated 1,098 Canadians killed in crashes in which at least one driver had been drinking.

The numbers do not necessarily suggest that the program has been unsuccessful. Diane Fahlman, TIRF communications and marketing manager, says that "all steps are incremental" in STRID. The monitoring report gathers information on what steps have been successful, and serves to "give ideas for new initiatives for what should be done."

According to Bob Mann, a scientist at the Centre for Addiction and Mental Health, the numbers must be seen in context.

"STRID was a long-range plan, and it takes time," he says. "With anything meaningful, you have to take a long-range perspective."

STRID 2001, the renewal of the first program, not only expanded its recommendations, but also broadened its scope to include serious injuries as well as fatalities. Some of its recommendations have been adopted. Five jurisdictions have some form of an administrative licence suspension, an immediate penalty that lasts for up to 90 days. Two provinces had alcohol-ignition interlock devices for convicted offenders by 1997, while nine jurisdictions had a vehicle impoundment program.



Various forms of mandatory assessment and rehabilitation programs, which may charge user fees to convicted drivers, are in place in nine jurisdictions.

Each province is individually responsible for implementing its own program, based on three key elements: communication about STRID enforcement through drinking and driving programs and legislation through tougher laws for offenders.

In Ontario, legislation requires stiffer penalties for alcohol-related driving offences, particularly for repeat offenders.

Fines for repeat offenders were increased in November 1998, in some cases by as much as 10 times. On a first offence of driving with a suspended licence, fines now range from \$5,000 to \$25,000, up from \$500 to \$5,000.

Also, the length of suspension periods for repeat offenders has increased. Third-time offenders previously lost their licences for three years. Now, the loss is for life, and can only be appealed after 10 years.

A copy of the TIRF report is available from (613) 238-5235. **SUE McCLUSKEY**

MDs use health clinic to deliver methadone

Clients benefit from access to counselling

A NEW METHADONE CLINIC IN London is providing clients with both medical and social services under one roof, through a unique set-up involving private physicians, the local health unit and AIDS committee.

The Counterpoint Methadone Clinic opened last year, after three family practitioners, Drs. Brooke Nostle, Ken Lee and Martyn Judson, all of whom ran methadone clinics out of their London offices, agreed that they could do more for those who were unable to succeed.

"I didn't think we were really helping a large proportion of addicts with these private practices," says Dr. Nostle. "In a sense we were helping people who were easier to help, but we were not helping people with the greatest needs."

Professionals such as Dr. David Marsh, clinical director of addiction medicine for the Centre for Addiction and Mental Health, agree that more types of services are needed. "We need more methadone treatment available in Ontario, and it needs to be available in a range of settings and program rules, so anyone with opiate dependence can find a treatment that works for them," he says.

Almost 200 physicians are licensed to prescribe methadone in Ontario. Most incorporate their new clients into existing practices, which may not connect them to other community resources. Another factor that has prevented greater accessibility is that some physicians are wary of taking on methadone clients for fear it may disrupt their practices.

The London doctors, as well as psychiatrist Dr. Gamal Sadek, teamed up with the AIDS Committee and the London Health Unit to set up the methadone clinic in the same offices as Counterpoint Needle Exchange.

"The doctors are essentially continuing their role of prescribing methadone and looking at it from a medical perspective," says Alex Berry, the clinic's director. "What we're able to add is to provide people with more time than doctors have, to work around community linkages and goal setting. We're doing case manage-

ment for these people in a way that doctors don't have time for."

Thirty methadone clients come twice a week on Monday mornings and Thursday afternoons to see doctors for their prescription and to do their urine test. "When people come here, they see the doctor for two or five minutes," says Berry, "and they see us for maybe 30 minutes, or maybe not. The option is here." They're also welcome to drop by anytime during the rest of the week. "We do all those other services which doctors sometimes try to do, but don't have time to do," he says.

Patient feedback from the clinic so far is positive, says Dr. Nostle. They report less involvement in high-risk behaviours and feeling more able to get on with their lives. In addition, one of Dr. Nostle's nurses says that his regular office is much more peaceful now.

"Part of it is that doctors have been able to download their high maintenance clients," says Berry. "I think that the people that we're seeing are people who have, as a gross generalization, greater needs than some of the methadone patients. They're typically people who also have needs around finances, legal issues and housing issues."

"I think we're doing a much better job at helping people than we did before," says Dr. Nostle. "The whole idea is to meet people on their terms. It's an enabling activity, it empowers people to make positive changes, to be kinder to themselves, their associates and to society." **TAMSEN TILLSON**



Epilepsy medication could help drug users

An epilepsy medication is showing promise as a treatment for a variety of addictive drugs.

Gamma vinyl-GABA (GVG) can potentially block the effects of a number of drugs — both stimulants and depressants — which sets it apart from other pharmacological therapies such as naltrexone or antabuse. So far, researchers have published animal research on cocaine and nicotine studies in the journal *Synapse* (vol 30). According to Dr. Stephen Dewey, lead researcher and a neuroanatomist at Brookhaven National Laboratory in Upton, New York, research reports on alcohol, heroin and methamphetamine are being finalized.

In different ways, all these drugs lead to an increase in the brain neurotransmitter dopamine, which activates feelings of pleasure. GVG, called Vigabatrin in Europe, prevents the build-up of dopamine by working on the GABA system. This system modulates dopamine production.

The researchers conducted a series of biochemical and behavioural studies with GVG using 10 techniques. "No other [potential medication] has been studied this extensively, or with all drugs of abuse," says Dewey.

One approach involved brain scans of primates before and after they had taken nicotine and cocaine. Those who had been given doses of GVG had normal dopamine levels, while those who didn't had elevated levels.

In another approach that looked at GVG's effect on behaviour, researchers examined the tendency for rats to return to places where they had received nicotine or cocaine. After receiving GVG, this behaviour significantly decreased. The scientists suggested this was a sign that GVG could help prevent external cues from triggering substance use in humans.

Whether this proves to be true needs to be verified in clinical trials, which researchers plan to begin with cocaine users by early 1999 at the University of Pennsylvania, says Dewey.

Since GVG has already been used as an epilepsy drug in Canada and Europe, some factors are already known about it. In terms of side effects, its impact is mild, mainly causing cuts in the visual field around the face. These primarily appear after three years of medication use, in five to 25 per cent of patients, says Dewey.

Unlike use for epilepsy, Dewey expects people in addiction treatment will take GVG for only several months and at a fraction of the dose, which has yet to be determined in the trials. As with all pharmacological treatments, it would be considered part of a treatment strategy that includes counselling. **ANITA DUBEY**

Research Update

Marketing effective treatments

To encourage the use of research-based interventions at alcohol treatment centres, Ontario researchers tested a social marketing model, which yielded initial success. After conducting a market analysis, including focus groups with service providers, researchers targeted Ontario's Assessment/Referral (A/R) Centres as the sites to which they would disseminate the Guided Self-Change program (GSC). GSC is a four-session evidence-based intervention, offered on an outpatient basis. With support of A/R managers, the research team co-ordinated 10 GSC training sessions that drew 170 A/R counsellors from across Ontario. One year after the training, 68 per cent of the eligible 35 agencies had adopted the GSC model. In addition, 85 per cent were using components of it. Only one agency chose to reject GSC. Though researchers note direct comparisons cannot be made, other attempts to influence health have resulted in 10 to 30 per cent of agencies adopting new programs, which suggests that a social marketing model is a promising approach.

Addiction, v.93(11):1703-1715. G.W. Martin et al, Centre for Addiction and Mental Health, Toronto, Ontario.

Improving housing access

Greater co-ordination among social service agencies helped homeless people with mental illness find housing. Researchers followed 1,340 clients at 18 U.S. communities during the first year of The Access to Community Care and Effective Services and Supports program (ACCESS), which was funded and designed to deal with service fragmentation. They also assessed interorganizational relationships of all relevant agencies in each community through structured interviews. Initially, five per cent of clients had an apartment or house of their own. One year after program implementation, 44 per cent had accommodation. Changes in use of other services, such as substance abuse care and job assistance, remained relatively modest. "This is the first study of which we are aware to demonstrate a significant relationship between service system integration and client outcomes," the authors point out.

American Journal of Public Health, v.88 (11):1610-1615. Robert Rosenheck et al, Veterans Affairs Medical Centre, West Haven, Connecticut.

Weight control for smokers

Early weight control interventions are crucial for smokers who want to quit, in order to ensure benefits of cessation are maximized, a new study advises. The Lung Health Study, which followed 5,887 smokers in the U.S. and Canada, found that 33 per cent of smokers who quit gained more than 10 kg in five years. Female quitters gained an average of almost 9 kg overall, while male quitters averaged about 8 kg. Among those who continued to smoke, gains averaged about 1 kg for men and 2 kg for women. Most of the weight gain occurred in the first year after quitting, but some gain continued to occur until year five. This result differs from previous studies, which suggest that initial weight gain eventually stabilizes or decreases.

American Journal of Epidemiology, vol. 148 (9): 821-830. Peggy O'Hara et al, Middle Tennessee State University, Murfreesboro, Tennessee.

Recommendations for depression

For the best treatment of patients with depression, clinicians should conduct a comprehensive assessment from a broad perspective rather than using a single theory to guide them, suggest researchers who conducted a literature review. They found that various approaches such as cognitive, behavioural or interpersonal therapy have "both supportive and conflicting evidence concerning their validity," which suggests that any one model is not best for all patients. Researchers also advise taking predictors of relapse into account when designing treatment plans. In terms of research, they noted the need for consistent definitions and measurement criteria for the common terms response, remission, relapse, recovery and recurrence. "We also recommend researchers view depression from a public health perspective; measure maintenance effects often, and conduct matching studies as well as more prediction investigations," they add.

Clinical Psychology: Science and Practice, vol. 5(4): 496-512. Arthur M. Nezu et al, Dept. of Clinical and Health Psychology, Allegheny University of the Health Sciences, Philadelphia, Pennsylvania.

Support lower-income mothers

The rate of psychiatric or substance abuse problems among mothers who are homeless or have low incomes is high relative to women in the general population. A study of 220 homeless mothers and 216 housed mothers on public assistance found similar rates of disorders between the two groups, with more than two-thirds having one lifetime diagnosis. However, their rates were considerably higher than women in the U.S. National Comorbidity Survey. For example, roughly 35 per cent of the low-income women had lifetime posttraumatic stress disorder, a rate three times higher than women from the national survey. The rate of major depression was about double that of women aged 15 to 40 from the survey, while the prevalence of alcohol-related disorders was almost twice as high. Unlike solitary homeless women, homeless mothers did not suffer disproportionately from schizophrenia. "Programs and policies designed for low-income mothers must respond to the high prevalence of DSM-III-R disorders," the researchers conclude.

American Journal of Psychiatry, vol. 155(11): 1561-1564. Ellen L. Bassuk et al, Dept. of Psychiatry, Harvard Medical School, Newton Centre, Massachusetts.





Drinking workers cause problems

A work environment that socially accepts drinking before work or during breaks, combined with poor co-operative spirit, was related to a higher number of problems for drinkers' colleagues, according to one of the first studies of its kind. Researchers surveyed random samples of 1,977 municipal employees from two different cities on co-worker drinking, staff cohesion and other factors. "As many as 40 per cent of employees report at least one negative consequence associated with co-worker substance use," the authors note. These included poor quality of work, having to do extra work, increased chance of injury for the work group and poor communication. However, when cohesion levels within the workplace were high, the negative impact of a colleague's drinking appeared to be attenuated. "Employees with the most problems reported both drinking climate and a work group that lacked cohesion," they add, noting that in such cases, "any one worker's alcohol problems may become everyone else's business."

Journal of Studies on Alcohol, 59: 608-618. Joel B. Bennett et al, Institute of Behavioural Research, Texas Christian University, Fort Worth, Texas.

Changes in eating disorders

The changing characteristics of patients with eating disorders, seen over 15 years in a Toronto clinic, have implications for diagnosis and treatment, a study suggests. Researchers analyzed records of 806 people referred for treatment between 1978 and 1994. One trend was that patients began dieting at a younger age. In

the last five-year period the age of onset was 15 years, down from 17 years in the first five-year period. Rates of purging and use of laxatives, diuretics and diet pills rose significantly. Combined with an increase in reported depressive symptoms, mood fluctuation and tiredness, these changes require specific assessment tools and treatment strategies, the authors say. Finally, findings of a drop in the percentage of women whose menstrual cycles were interrupted call into question the use of this symptom as a prerequisite for diagnosis.

Journal of Psychosomatic Research, vol. 45(6): 533-547. Stephanie Krüger et al, c/o Centre for Addiction and Mental Health, Toronto, Ontario.

Car accidents and stress disorder

Chronic posttraumatic stress disorder (PTSD) in motor vehicle accident victims can be predicted by their persistent health and financial problems due to the accident. A study of 967 consecutive victims at an emergency clinic found that 23 per cent of the group had PTSD at three months, and 16 per cent did at one year. Approximately half of all participants met DSM-IV criteria for various symptoms at both time points, the authors note. This was "especially noteworthy" given that a high proportion of subjects were either not injured at all or had suffered only soft tissue injury. Indeed, injury severity was not significantly related to PTSD diagnosis or severity. A factor that was related was compensation claims. At one year, only eight per cent of participants who had no compensation claims had PTSD, compared to about 25 per cent

who were either planning or had started compensation proceedings.

Journal of Abnormal Psychology, vol. 107 (3): 508-519. Anke Ehlers et al, Dept. of Psychiatry, University of Oxford, Oxford, United Kingdom.

Treatment climate helps patients

Patients functioned better in supportive treatment climates that offered active support, engaged patients in discussion of personal problems and promoted practical skills. A study that assessed 89 residential substance abuse and psychiatric programs found that patients in such programs were also more involved in the community and used programs' in-house health, social and recreational services more often. Results also showed that more personal expression and practical orientation were especially beneficial for patients with greater psychiatric impairment. The results held when both patients' and staff members' perceptions of the treatment climate were considered, the authors add. They also pointed out that when a treatment program emphasizes practical preparation for community living, "more competent patients may increase their participation in services that are centred around broader life issues."

Journal of Clinical Psychology, vol. 54:1137-1150. Christine Timko et al, Veterans Affairs Health Care System, Palo Alto, California.

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Gambling prevention for teens

BY CHRIS HENDRY

TAKE A RANDOM SAMPLE OF adolescent problem gambling prevalence studies and the odds are they will show the same results — more adolescents are gambling, and they're more likely than adults to develop problem gambling behaviours.

In 1997, a Harvard study found that 3.9 per cent of youth from the general population had a gambling problem versus 1.6 per cent of adults. Also reported in 1997, the Alberta Alcohol and Drug Abuse Commission found that in comparison to the Alberta adult population, adolescents were "four times more likely to be at risk of experiencing some problem with their gambling (23 per cent versus 5.4 per cent)." And more recently, this past year psychologists Jeffrey Derevensky and Rina Gupta of McGill University — researchers who are part of a growing movement seeking to reconcile treatment with prevention — reported that 55 per cent of adolescents were engaged in gambling activities, with approximately four to six per cent having a serious gambling problem.

The McGill study also discovered that adult problem gamblers can trace the start of their problem behaviours to "between the ages of 10 and 19." Derevensky says researchers must now move beyond the study of prevalence to developing prevention strategies.

"Once you understand why, you can start to work on prevention and education," he says. By reaching potential problem gamblers when they are still young, it ultimately should reduce the number of problem gamblers overall.

Teens report participating in public gaming, such as lotteries, and private gambling, such as sports betting.

Though the need is clear, Derevensky is critical of "the lack of prevention programs aimed at adolescents and youth," and is dubious of the content of existing programs. Though Loto-Québec launched its "Count Me Out!" classroom program last November, which aimed at preventing "young people between the ages of 8 and 14 from forming an addiction to games of chance" it has been greeted with some skepticism from the province's academic community as to its effectiveness. The Ontario Lottery Cor-

poration relies on stiff legal penalties for vendors who sell to or cash-in winning lotto tickets held by adolescents.

Other strategies, such as the one developed by the Harvard Project, are criticized for their reliance on simply educating youth on the low probabilities of winning as a way of discouraging them.

In seeking to create a more comprehensive approach, McGill researchers are developing a model that will, Derevensky says, focus on, "one, the need for awareness; two, the appropriateness of the school system to implement the prevention; three, the teaching of successful coping and adaptive skills that would prevent the development of problematic gambling; and four, the identification, assessment, and referral of students whose gambling behaviours is indicative of them being at risk."

Also currently in development, researchers in the problem gambling program at the Centre for Addiction and Mental Health are developing a model that seeks to combine the emotional aspect, through role-playing to help kids remain aware of the mathematical odds during the activity's emotional highs and lows, along with education about the probabilities of winning to foster critical thought about the activity.

However, the success of any prevention model for adolescents — whether it is directed at gambling, alcohol, smoking or other drug use behaviours — is plagued by an inherent paradox. As John MacDonald, addiction therapist with the Centre says, with an "it-can't-happen-to-me outlook and a present-oriented mentality, it's hard to instill in adolescents any thought of long-term negative effect."

MacDonald points to several other obstacles any strategy will



have to counter. For instance, adolescents have an inherent desire to develop competency and skill — in this case mastering something such as perfect Black Jack strategy — to forge a unique identity to distinguish themselves from others. As well, gambling may also be a means of dissociating oneself from life's little struggles in lieu of the coping skills possessed by adults.

But as Roger Horbay, addiction therapist with the Centre's problem gambling service says, especially given the recent introduction of VLTs to the province, "we're dealing with the first generation of computer literate adolescents accustomed to playing video games and mastering them, but you can't win these games — not in the long-run. And without adequate education about these games, there is no informed choice." ■

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New approaches to trauma therapy

A focus on women's strengths,
not symptoms

BY DIANA BALLON

FOR 40-YEAR-OLD ADRIENNE, THE BIRTH of her second child coincided with a depression that has lasted off and on for almost a decade. While Adrienne* sees her postpartum experience — and stress at work — as triggering these episodes, she suspects that childhood abuse has had an important effect.

"I grew up in an environment that did not support women as human beings," she says. As a child, Adrienne was sexually assaulted by an older brother and from the age of eight, her father burdened her with his problems.

Like Adrienne, two-thirds of women who seek help for mental illness have a history of emotional, physical and/or sexual abuse or severe neglect, studies show. These women have generally been diagnosed with more than one psychiatric label, most commonly major depression, and anxiety, posttraumatic stress and borderline personality disorders.

Women with a history of abuse are treated with *more* psychotropic medications and with higher doses than women with similar demographics and diagnoses who have not been abused, according to a study in the *American Journal of Psychiatry*. Those experiencing childhood trauma also have an earlier onset of illness, more frequent hospitalizations and longer hospital stays, says Susan Engels, clinical nurse specialist in the Toronto Society, Women and Health program.

While historically, the abuse women suffer has been under-reported in psychiatric settings, a greater recognition is fostering more sensitivity and interest in therapy dealing with trauma.

This reflects the disillusionment that many "psychiatric survivors" have with traditional medical interventions. They describe them as retraumatizing, due to a power imbalance between doctor and client, and a greater focus on the client's symptoms instead of her strengths.

Despite her misgivings with a medical model approach, Adrienne says that antidepressants have helped her through the most difficult periods. As Dr. Donna Stewart, chair of

Women's Health at the University of Toronto and The Toronto Hospital, corroborates, "abuse can cause permanent changes in brain chemistry and changes in the way the brain functions, which makes medication effective in some cases," a fact that has been supported by PET scan research.

Substantial literature has also emerged on the damaging effects of trauma on women's emotional well-being. However, this work has focused almost exclusively on the effects of physical and sexual abuse, and less on the influence of emotional abuse, says Dr. Alisha Ali, a researcher for the women's mental health research program at the Centre for Addiction and Mental Health and the University of Toronto. In part, this is due to the lack of a widely accepted methodology for assessing the effect of emotional abuse, and the fact that there is often an overlap in the types of abuse women suffer.

Awareness of a woman's history helps tailor treatment to her need. One example of a trauma-oriented therapy is WRAP (Women Recovering from Abuse Program), which is jointly run by Sunnybrook and Women's College Health Science Centre and the Centre for Addiction and Mental Health in Toronto.

"Unlike some other forms of therapy which focus primarily on diagnosing illness and reducing symptoms, WRAP recognizes the social factors that influence women's health, such as stressful life events, greater risk of poverty and discrimination, and juggling roles of mother, worker, partner and caregiver to elderly parents," says Engels, co-ordinator of the program.

The therapy is collaborative and acknowledges the strength and knowledge that women bring. Rather than encouraging women to relive the traumatic experiences in the safety of the therapeutic relationship — an approach in some trauma work — the focus is more on the present. Instead of emphasizing symptoms, WRAP stresses the "way the women come to communicate with others and live in the world and establish relationships with themselves and others around them," Engels says.

Typically, women who come to the program have harmed themselves through self-mutilation or drug abuse, and have adopted unhealthy eating patterns such as bingeing, purging or using laxatives. Many have been victims of violence as adults, and most have difficulty in relationships.

Treatment at WRAP begins by exploring the women's definitions of trauma and how abuse has influenced their sense of themselves. A woman might, for instance, begin to see the connection between cutting herself, feelings of self-hatred and shame, and the perception that feeling physical pain and seeing her own blood make her feel real. As Engels explains, people experiencing trauma generally alternate between two distinct states: being hyperaroused and feeling constricted or numb. It is the numbness that women describe as particularly distressing.

Through the program, women are helped to take control over their lives, while learning ways to take care of themselves. In one exercise, the senses are used to help modulate their emotions. Different sensory stations are placed around a room. For example, one area will focus on smell, with cloves, cinnamon and scented candles. Another will be for touch, with velvet, sandpaper and stones, and another will be for taste, with gum and candies. The women use these sensory experiences to learn how to mediate traumatic memories that often get triggered through the senses. For example, a woman whose abuse may be triggered by the smell of a man's sweat could carry a handkerchief with cloves to smell when a man with a similar odour threatens to reactivate the trauma.

Research indicates that people suffering from trauma have differences in storage and retrieval of memories for traumatic events. In "non-declarative" or traumatic memory, the brain can't make sense of the raw sensory information it receives as sights, sounds and physical sensations. Sensory fragments thus remain isolated and are not pulled together to form a narrative memory. When the fragments are later activated, they may trigger flashbacks or a relived experience of the original trauma.

For Adrienne, staying well has involved cultivating her own range of strategies. She's tried exercising, writing, pursuing interests in dancing and singing, helping others through her work and looking at photos that remind her of happy times with family and friends. "These things help me stay connected to who I really am; they help me remember that because I experience depression sometimes, it doesn't define my whole reality, all the time." ■

*not her real name

Community treatment orders

A new bill heats up the debate

BY SUE McCLUSKEY

SOME PEOPLE SEE THEM AS A WAY TO increase the quality of life for the mentally ill. Others see them as a way to force patients to accept treatment unwillingly under the threat of incarceration.

The mere mention of community treatment orders (CTOs) in the mental health community is enough to open a gulf of opposition and misunderstanding.

Bill 78, MPP Richard Patten's proposed changes to the Mental Health Act, is the most contentious private member's bill to hit Ontario in a long time. Including a CTO provision, Bill 78 demands attention not only because it passed a second reading this past November, but also because the Ministry of Health is currently looking at ways to update the existing Mental Health Act. With CTOs already in place in Saskatchewan and in many U.S. states, it is reasonable to expect that the ministry will consider CTOs as an option.

The changes that Bill 78 contains cover two main areas: CTOs or "leave agreements," and patients who suffer from what is referred to as the "revolving door" problem.

The proposed new subsection (33.1-33.3) spells out an outpatient "leave agreement" that is already legal, though vaguely worded and rarely employed, under Section 27 of the current Mental Health Act.

Under the existing legislation, a leave agreement is described in two sentences. The "officer in charge" — the administrative head of a psychiatric facility — can place a patient on a "leave of absence" from the facility for up to three months, on the advice of a physician. The second sentence says the leave may be permitted on the terms and conditions the officer prescribes.

Bill 78 spells out these terms in more detail.

"That little Section 27 is, in my opinion, woefully inadequate," says psychiatrist Dr. Ian Musgrave, who has been working with the Ministry of Health. "Patients deserve a far better community tenure by having a more comprehensive, community-focused section of the Mental Health Act."

The proposed changes apply to people already detained in a psychiatric facility, to provide treatment "that is less restrictive and less intrusive to the patient than being detained in a psychiatric facility."

Physicians can enter a "leave agreement" with a patient or substitute decision-maker, if they

feel the patient needs continuing treatment and supervision while living in the community. The patient is required to comply with a treatment plan and attend required appointments. After six months, the agreement is reviewed.

If a patient fails to comply, the physician must make an effort to inform and help the patient, and can then file a notice to return the person to the psychiatric facility for examination.

Opponents focus on two main points: the fear of forcing patients to take medication in the community, and the need for more community supports, such as employment and affordable housing.

CMHA president, Ontario Division, Janemar Cline, argues that it is such community supports that are responsible for any success that CTOs may have. In the CMHA publication, *Network*, she says, "Whenever forced treatment orders are being used they are working with an awful lot of other community supports in place... I think if you have all those other kinds of supports your life is becoming automatically more satisfactory and the enforcement then becomes unnecessary. I don't think we need to have legislation to make people take their medication; what we need is a lot more money spent on community treatment."

Musgrave says that, to achieve success with the most seriously ill, community support nearly always includes medication therapy, together with a wide range of other supports. Working with assertive community treatment programs across the province, he has found that in roughly 10 per cent of cases, the illness prevents the person from staying on medication. This, he says, "is the group that society's really letting down, and that's the group that CTOs are trying to address... We coerce them to take medicines when they're in hospitals — how can we just leave them to the streets until they become in rags or hungry or homeless, before somebody can intervene?"

He sees CTOs as a component of assertive community treatment, used in a small minority of cases.

Forced medication is still a contentious issue,

and some patients' groups fear that CTOs will make it easier to coerce people into taking medication and keep them in a passive state.

Diana Capponi, a psychiatric survivor and head of the Ontario Council of Alternative Businesses, sees the proposed changes as veering away from what should be the main focus: quality of life. "I think that the medical model, in particular, tends to rule out quality of life issues," she says. "The importance is to have friendly services to people, to provide people with options in their lives and to have decent housing."

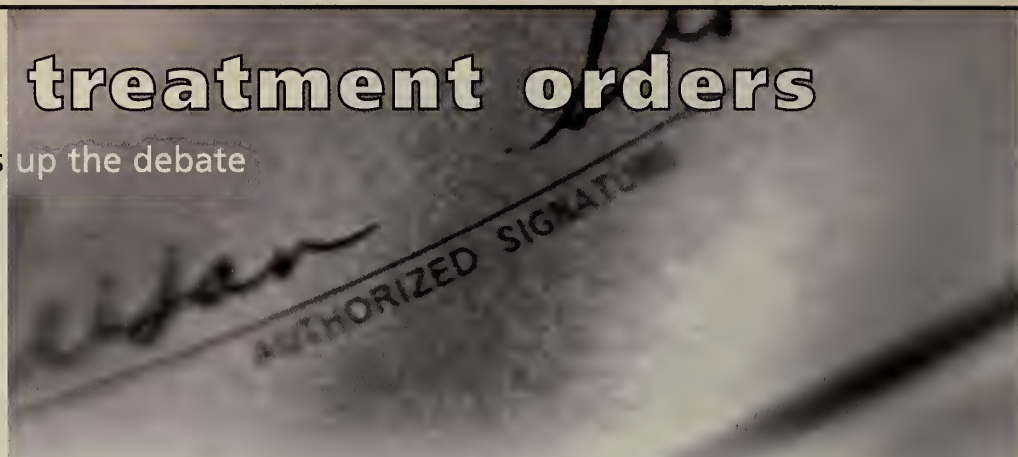
"We need to get more accountability from the physicians, and the people who are in a position to make decisions like that."

Capponi also feels that CTOs are a civil liberties issue for more than just psychiatric patients. Once "the right to refuse treatment" is taken away, she says, "we're opening the door to other losses of liberty."

The leave agreement goes hand in hand with the other proposed changes, which address the needs of a small segment of the population known as "revolving door" patients, who are admitted to hospital, stabilized, discharged, and then re-admitted in an ongoing pattern.

Patten says that his bill is based on the "human situations" he was hearing about from constituents. With "revolving door" patients, family members who recognize a pattern of deterioration want to be able to get the patient admitted to hospital as soon as possible. But in the early stages of deterioration, the patients "are not severe enough to be accepted by the consent board," Patten says. "So it's almost as if they have to do something — threaten somebody or threaten suicide — before they can be taken seriously."

CTOs are just one possible facet of changes with outpatient treatment in Ontario. Musgrave concludes that any changes to the Mental Health Act should come after input from many sources. "The government is still exploring. I hope there'll be a lot of public consultation and thorough evaluation of the changes that might come about." ■



Criminal system begins to recognize health issues

BY KALYANI VITTALA

TREATMENT VERSUS PUNISHMENT is the natural dichotomy in the intersection between the mental health and addictions fields and the criminal justice system.

But the two sides appear to be moving toward each other as they seek preventative and rehabilitative measures to deal with offenders with specific behaviour problems, who have not been served well by the generic "get tough on crime" policies that became prevalent during the 1980s in the United States and Canada.

For much of history, people with mental illness have faced prejudice — stigmatization to the point where complete reintegration into society became almost impossible. The same can be said for illegal drug users, particularly since marijuana use was identified as a major societal problem in the mid-1960s. The prevalence of these attitudes did not leave the justice system untouched, and it is only recently that there has been any amelioration of the problem.

But as more research is compiled, professionals in both fields, as well as society at large, are slowly undergoing a liberalization of these attitudes.

Much of the research suggests that a direct causal link between mental illness or substance abuse and violence is tenuous at best. It also suggests that when individuals suffering from addiction or mental health disorders have faced marginalization and poverty, they are at higher risk of turning to crime. These types of findings have forced governments to review their policies.

In 1992, changes in the Criminal Code made it possible for convicted mentally ill offenders to be processed, not as criminals, but as people with psychiatric disorders. This means they would be remanded to the forensic unit of a psychiatric hospital for treatment, rather than to jail.

"There seems to be a pretty good understanding of mental health issues in the justice system these days," says Dr. Howard Barbaree, clinical director of the forensic program for the Centre for Addiction and Mental Health. "The burden has been transferred from the correction system to the mental health system, which is appropriate."

But still the numbers of people with psychiatric disorders who come into conflict with the justice system is increasing by the rate of about 10 per cent a year.

There are also anywhere from 1,600 to 8,000 people in Ontario's jails who suffer from some form of mental illness.

The problem, says Dr. Richard Schneider, legal counsel for the Ontario Board of Review, is the increasing deinstitutionalization of psychiatric patients. Combined with inadequate or inaccessible community services, this creates a problem.

"The civil system is letting too many of them leak through and they are ending up on the forensic side."

Despite such setbacks, health and justice professionals in Ontario are attempting to find solutions. One is the mental health court which started in Toronto last May, and is responsible for saving hundreds of remand days, says Dr. Schneider. Another is the new drug treatment court. (see stories, pages 12-13)

In addition, correctional services is implementing projects that provide appropriate mental health care to inmates, says Dr. Barbaree. "There are



strong indications of reductions in recidivism among those who receive treatment."

The same is true for substance abuse treatment. The director of corrections, research and development for the Solicitor-General of Canada, Dr. Robert Cormier, says "We are making a very determined effort to deal with substance abuse among offenders."

He says that substance use is one of the greatest risk factors when it comes to the "revolving-door" syndrome of repeat offences.

"We have a different attitude towards corrections than the United States. Clearly the Canadian system is very much oriented towards rehabilitation."

About 10 per cent of the federal inmate population is serving time for a drug offence, while more than 50 per cent have an alcohol or other drug abuse problem.

The fundamental problem, according to Dr. Patricia Erickson, senior scientist for the Centre for Addiction and Mental Health, is treating drug use as a criminal issue rather than a health issue.

"Justice isn't a health system. It's there to serve as a deterrent. But if the only predation involved is self-predation, then perhaps punishment is not the appropriate response."

Dr. Erickson recently authored a paper on drug-related violence in which she argued the primary link between drug abuse and violence and crime was caused by socio-economic conditions rather than the actual abuse of a chemical substance.

She calls for more consideration of harm reduction alternatives for drug users, both within and outside the criminal justice system.

While research cannot emphasize strongly enough the environmental forces that bring people with mental illness or substance abuse problems into conflict with the law, several studies do find a direct link when individuals suffer from both.

"...[S]ubstance misuse is a major risk factor for violence in patients with major disorders," writes Dr. Andrew Johns, department of forensic psychiatry, Institute of Psychiatry in London, in last November's issue of *Current Opinion in Psychiatry*.

He also points out that substance misuse is the most common mental health problem found among prisoners and that "psychiatric services should aim to develop a [concurrent disorder] response" among prison inmates in order to reduce recidivism rates.

Although the mental health care community and the justice system are beginning to pull together, the system is far from perfect.

There are still too few forensic beds available for mentally ill offenders, and those beds are often taken up by people who could just as well be served in the general psychiatric population, says Dr. Barbaree.

Education and outreach are only making marginal inroads in prevention for groups, especially children, who are at high risk for substance abuse.

And today's criminal justice system, which still emphasizes the pejorative rather than the rehabilitative, frequently places mental health care professionals in the dilemma of balancing responsibility to their patients with responsibility to public safety. ■

Drug court diverts offenders to treatment

CANADA'S FIRST DRUG TREATMENT COURT OPENED IN Toronto on Dec. 1. The pilot project, modelled after U.S. drug courts, oversees the progress of people charged with drug-related crimes as they go through a treatment program. The court diverts offenders from jail and into a program that could reduce both repeat offences and the harm caused by drugs.

The Toronto Drug Treatment Court was the inspiration of Judge Paul Bentley, a provincial court judge. He says that he was tired of seeing people reappear in his court after being jailed for drug possession just months earlier. He decided that there had to be a better way, and started researching the American experience.

The first new-style drug court was established in Dade County, Florida, in 1989 by Janet Reno, then a local prosecutor and now the U.S. Attorney General. The idea took off, and by 1998 there were more than 400 such courts in 44 states.

While there are variations among the drug courts, they do share certain characteristics. There is judicial supervision of the treatment program, which is based in the community. Defendants in need of treatment are identified and referred to the drug court as quickly as possible after arrest. The participants are closely supervised and are obligated to visit the court and attend treatment sessions regularly. They also undergo frequent random drug screens. And they are subject to a variety of sanctions and rewards imposed by the court, according to their behaviour and progress in the program. About a dozen people had passed through the Toronto court by the end of the year.

"The benefits of the drug treatment court are that we've been able to engage clients who in the past would have just gone to jail, then hit the streets and continued criminal activity and drug use. This breaks the cycle. It changes attitudes and behaviour," says Dave MacIntyre, court liaison from the Centre for Addiction and Mental Health.

In the Toronto court, which accepts people with heroin or cocaine dependence, potential participants are screened by the treatment provider and the Crown prosecutor. People who pose a risk to the community or have been charged with drug trafficking for commercial gain may not be eligible.

Those who are eligible for the program can enter in one of two ways. If they have no criminal record and have been charged with

minor drug-related offences, such as possession, they can enter the diversion stream soon after being charged. If they complete the program successfully, the charges can be withdrawn or stayed. Those with a recent criminal record or who are facing more serious charges, such as drug trafficking, may be eligible after they have made a plea on their charges. Sentencing is then postponed until after they have completed the treatment program. Successful participants could receive a non-custodial sentence.

The Toronto pilot was in development for more than a year. Judge Bentley approached the federal Department of Justice, the Centre for Addiction and Mental Health, court and public health officials and the police. He also formed a community advisory committee composed of agencies that provide social services, housing, education and prevention programs. The Justice Department and the federal Solicitor General, through the National Crime Prevention Centre (NCPC), allocated \$1.6 million over four years to fund the project and evaluate it.

The treatment component can last a year or more. MacIntyre attends court and acts as contact between the potential client and the treatment centre. He also assists the client in accessing other services, such as housing and social assistance.

Clients have to demonstrate that they have stabilized housing, control of their drug problem and are involved in a job or training program to be considered successful in the treatment component, says MacIntyre.

The U.S. experience suggests drug courts do work. South of the border, 45 per cent of people convicted of drug possession in a regular court will commit a similar offence within two or three years. Drug courts, on the other hand, lowered the recidivism rate to between five and 28 per cent. People who entered drug courts are also more likely to successfully complete their treatment programs and reduce or end their drug use.

CRAIG SMITH



Drug a day in the life court

The first person to appear in front of Judge Paul Bentley one recent afternoon in drug treatment court is a woman who entered the program a week earlier. She has appeared for all her court dates and appointments for treatment, although she says, "It's not easy."

There are no results from her urine screen yet, but she tells the judge she's clean. Dave MacIntyre, court liaison for the Centre for Addiction and Mental Health, reports that she has been extremely co-operative. For example, when the client came for her treatment appointment and was mistakenly sent home, she called MacIntyre

and corrected the mix-up.

The judge, pleased with her progress, tells her to continue attending her appointments. Since she is showing signs of progress, she now has to appear in court only once a week, instead of twice weekly on the afternoons the court is in session.

A male client appears. Charged for possession of a small amount of crack cocaine, he wishes to enter the program. Judge Bentley asks him: "Are you sure that this is the time in your life that you want to do this?"

The man replies: "This is something I have to do."

An assessment appointment is scheduled, and the judge asks him to report back to court in two days.

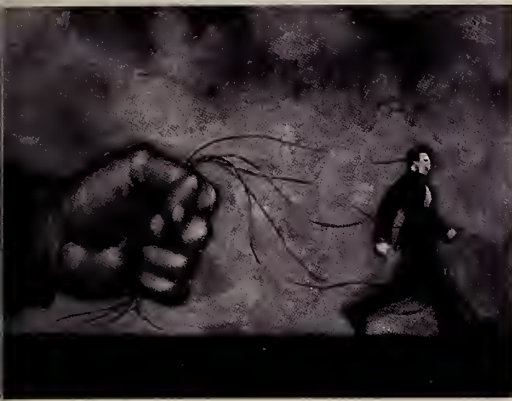
Another woman has been charged with two counts of possessing cocaine. She tells the judge

she's had treatment before. The judge warns her that this program will be different — and more onerous.

"There may be sanctions if you use drugs and you say that you're not using," he tells her. "It's easier to plead guilty."

Bail is arranged and the papers are signed right there in court. This procedure differs from the usual practice in other courts, but is designed to give participants an immediate benefit for participating. An appointment for assessment is made, and she is told to return to court in two days.

Unfortunately, she does not appear in court for her second appearance, and the court liaison reports that she missed her assessment. The judge issues a bench warrant for her arrest.



Mental health courts connect people to services

CCOURT 102 IN TORONTO'S OLD CITY HALL HAS BEEN described as a place where you close the book and open your heart. Most of the people who appear in the court are accused of minor offences — shoplifting, annoying passers-by in the street, or breaking into an apartment to retrieve belongings after being evicted by a landlord.

Besides being poor and often lacking housing, what they often have in common is mental illness. The chief role of Court 102, the mental health court, is to speed up the process of determining the issue of fitness — whether the person is legally fit to stand trial.

Like others who work at the court, mental health court worker Anita Barnes, of Community Resources Consultants of Toronto, got tired of watching people who were ill or poor sitting in jail while awaiting an assessment. Generally, someone waited five to seven days in order to be assessed for fitness. Court 102 is designed to fast track the process. Since May 1998, when the court was launched as a pilot project, 308 people have been assessed. Assessments within the next day or two are the norm.

A number of other benefits accrue when staff, including a judge, crown attorneys, duty counsels, psychiatrist, court officers, two mental health court workers and a case manager, are experienced in mental health issues and work together every day.

Beyond the fitness issue, a part of Barnes' job is to assist with diversion — moving less serious offenders out of the criminal justice system toward treatment. Last spring, the provincial government allocated almost \$470,000 for diversion programs in Hamilton, Windsor, Peel, Toronto, York, Durham, Ottawa and Kenora.

Generally, if a person agrees to be diverted and to follow a prescribed program, the Crown will withdraw charges, saving the person from a criminal record. Even when clients are not deemed good candidates for diversion because their crimes are too serious, says Barnes, attempts are made to look at broader issues, such as housing, medical needs and community support, to avoid conflict with the law in the future.

In Ottawa, a special pre-trial with crown and defence attorneys can be

convened to try to divert people with mental health problems into treatment. "The crown attorneys are very good in recognizing mental health issues and really wanting to deal with them in a better way than throwing people in jail or putting them on probation," says Mary Kelleher, a court outreach officer who works at the Canadian Mental Health Association office in Ottawa.

Dennis DeSalvo, manager of the mental health court support program in Hamilton, says he sees his role as a broker to help people access existing services.

Many in the system say that such programs are long overdue to stem *de facto* criminalization of mental health patients. Since the 1960s, the trend to deinstitutionalize patients and to close hospital beds has not been matched by an expansion of community-based services. The criminal justice system — and jail time — have often been used both as a stopgap for people with mental health problems and as a way for people or their families to appeal for help. Perversely, the best way to get treatment can be to resort to violence, thereby crossing over into the criminal justice system. An estimated 30 per cent of those in Ontario's correctional services have some form of mental illness.

In Ottawa, several high-profile crimes, including the killing of newscaster Brian Smith by a person with schizophrenia who was suffering delusions, have sparked concerns that the system is letting too many people with severe mental disturbances slip through the cracks. By siphoning off minor offenders, the hope is that the few people with violent histories will move to the front of the line for forensic treatment.

At the same time, many believe that such court-based programs would be less necessary if those with mental illness were provided with adequate supports in the first place. If better housing, addiction treatment and support networks were available, fewer mental health consumers would end up in trouble with the law, appearing in provincial court, or taking up scarce forensic beds. And, of course, diversion only succeeds if there are resources and supports in place in the community.

PENNY STUART

The caring court

An accused person goes to Court 102 when a justice of the peace or a judge signs a Form 48 asking for a psychiatric assessment to determine whether the person is fit to stand trial. Once in Court 102, they encounter a process that is a little different than most courts. The process is designed to be more sensitive and less adversarial. Using an informal and consultative approach makes it more human.

Assistant Crown Attorney Margaret Creal describes Court 102 as a place where patience is a prime

virtue. When clients become agitated, court officers are likely to back off to give them time to compose themselves rather than moving in immediately to gain control. When a client does not understand, Judge Ted Ormston, who presides over the court, takes the time to review the case. "Hard calls have to be made sometimes, but it's the least adversarial way of doing it. You can reach consensus more readily when you are on a face-to-face basis."

Duty counsel Joe Wright also describes the court as less adversarial in tone. "As far as I am concerned, I still always take my instructions from the client. If

the client told me to dispute everything, I would take my approach from them," he says. "(But) the process is more interested in getting the person released, stabilized and in contact with medical care... It is a more integrated approach."

Court worker Anita Barnes was initially worried that people would be labelled as coming from the "crazy" or "nut" court. Instead, what she has seen is genuine human concern and caring. "Everyone in the court works to do the best thing," she says. "You look at the individuals on the stand and think about what they have gone through to get to this point."

Q & A

Facts on addiction, mental health and crime

What is the relationship between mental illness and criminal behaviour?

People with mental illness are increasingly entering the criminal justice system. But often, it's because they're more likely to be noticed and arrested for minor "nuisance" offences in public, rather than for serious crimes.

The lack of community supports, housing issues and poverty, factors which people with mental illness often live with, make them more vulnerable to detection for such behaviours.

What about violent behaviour?

People with mental illness are more likely to be victims of violence than perpetrators. A recent U.S. study found they were 2.5 times more likely to be assaulted than the general population.

Unfortunately, many societies believe that mental illness is linked with violence. The reality is that three to four per cent of violent behaviour in North America can be attributed to mental illness.

In general, the conditions likely to increase the risk that someone becomes violent are the same, whether a person has a mental illness or not.

One U.S. expert panel, commissioned by the National Institute of Justice, has classified the risk factors for the few who do commit acts of violence into four categories. First, they note that personal factors, such as age, gender, control of anger and impulsiveness are relevant. Second, a person's developmental factors, such as a history of child abuse and violence, increase the risk. Third, current environmental factors, including stress and social support, also play a role. Finally, clinical factors are considered. Research suggests that some people with neurological impairments, such as brain injuries or psychoses leading to delusions, may be at higher risk, as are those who have both a major mental illness and a substance use disorder.

The combination of these factors may indicate a greater risk of violent behaviour, but they do not predict violence.

Do drugs make people more violent?

Alcohol is the only psychoactive substance whose consumption has been shown to increase

aggression, but this effect depends on other factors such as the setting in which it's consumed and personality traits.

Cocaine, hallucinogen, amphetamine or PCP use alone does not stimulate aggression. Marijuana and opiates temporarily inhibit violent behaviour.

Crimes committed by users to obtain drugs or money don't tend to be deliberately violent, but most often include drug dealing, theft, robbery or prostitution.

Because many drugs are illegal, the link between violent crime and substances is more related to drug distribution and marketing. Many feel the system leads to violence, rather than drug use itself.

If not violence, then doesn't drug use increase the odds of committing a crime in general?

It's true that the level of substance use is high among inmates. In one study of Canadian federal offenders, 33 per cent said they committed crimes under the influence of drugs, and 44 per cent said they did so under the influence of alcohol.

But many studies show that users who commit crimes often engaged in such behaviours before they began abusing substances. Those who begin to commit crimes after becoming addicted are often from lower socio-economic classes, as middle-class users may have enough money to support their addiction.

Both drug use and crime tend to occur in situations where a number of other non-conforming behaviours exist. There is no simple cause and effect relationship.

Again, developmental, environmental and personality factors are involved.

What are prevalence rates of people with mental health or substance problems inside the correctional system?

A random sample of 1,925 federal inmates with Correctional Service of Canada found high rates of mental illness. Almost eight per cent had a psychotic disorder, 22 per cent had a depressive disorder, 44 per cent had an anxiety disorder,

and 57 per cent had an antisocial personality disorder. These rates are at least five times higher than the general population.

The study of 503 federal male offenders found that more than 30 per cent used substances at least a few times a week in the six months before they were arrested. More than 57 per cent had been in a treatment program in the past.

Screening tests for drug abuse revealed that 28 per cent had moderate to severe problems in the six months prior to their arrest.

Are there gender differences?

Women outnumber men in all major psychiatric diagnoses, except for antisocial personality disorder, and this is true in prison as well. A Corrections Canada study found that federally incarcerated women were three times as likely to be depressed than incarcerated men, while in the general population, their rate of depression was double that of men. Female inmates were also three times as likely to have received mental health treatment in the community as men.

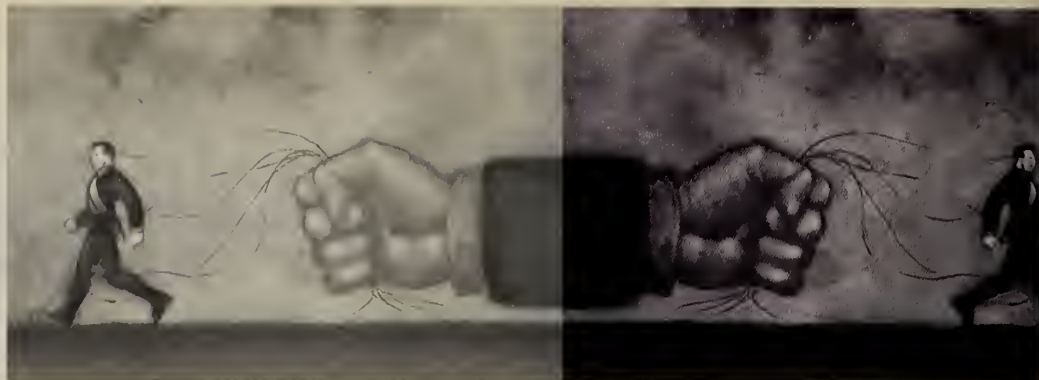
Women in prison also outnumbered those in the general population in terms of their diagnoses. Inmates had a seven per cent lifetime prevalence of schizophrenia, compared to one per cent in the general population. Rates of drug and alcohol abuse were 26 per cent and 36 per cent respectively in the prison population, compared to 3.8 and 4.3 per cent.

What can help in terms of prevention?

Research shows, again and again, that treatment can help where health factors — either mental illness or addiction — are likely to involve people with the criminal system. Adequate social services are also important, particularly where there is a risk of violence. ■

Sources:

Current Opinion in Psychiatry, American Journal of Psychiatry, U.S. National Institute of Justice, Correctional Services of Canada (Patterns of Alcohol and Drug Use Among Federal Offenders as Assessed by the Computerized Lifestyle Screening Instrument; Prevalence, Nature and Severity of Mental Health Problems among Federal Male Inmates in Canadian Penitentiaries; Mental Health Strategy for Women Offenders)



Women and AIDS

If you require convincing that women and AIDS is a worthy research topic, *Women, Drug Use and HIV Infection* should have you persuaded by the end of its pages. The convergence of drug use, sex in exchange or to raise money for drugs, and unsafe sex with a drug-using partner places women at a unique risk for HIV. According to the authors, 46 per cent of cases of HIV infection in women in the U.S. are directly attributed to injection drug use, and an additional 18 per cent are from sexual contact with an injection drug user.

This collection of 12 research articles is based on two studies funded by the National Institute of Drug Abuse (NIDA). Both aimed "to monitor HIV risk behaviours and seroprevalence levels in out-of-treatment drug users." The initial study had no gender quota while the second set a minimum of 30 per cent participation by women.

The authors seem to have paid attention to racial and cultural diversity, both in attracting subjects and in research development. Research participants include native Alaskan, African American, Hispanic and white women.

Study discussions frequently incorporate how systemic factors affect the decisions women are able to make. Multiple sexual partners, drug use prior to sex, and the women's own perceptions of risk all impact on women's HIV protection behaviours.

Few articles describe interventions beyond offering education, discussing personal risks and developing individual care strategies. An exception is the chapter "Effectiveness of HIV Interventions Among Women Drug Users." The study tested an innovative intervention against a standard one in male and female injecting and crack cocaine users in Miami. The standard intervention consisted of pre-HIV test counselling, HIV prevention education and appropriate referrals. The innovative intervention included a gender-based discussion "The Rules of the AIDS Game" for men and "The Recipe for AIDS Safety" for women with the advice, "What spoils the dish is HIV... Learn how it can spoil the dish so you can serve a healthy meal." Given discussions on the need for women to break away from traditional gender roles to assert themselves, especially in terms of condom use, the approach using a "recipe" metaphor seems contradictory.

No analysis is presented, beyond a recognition that not all people follow culturally based gender roles.

Overall, the studies are thorough and important, though largely epidemiological. The findings as they relate to crack use and increased risk of infection are particularly sobering. To use a slogan from HIV education campaigns of the early '90s, AIDS may not discriminate, but historically AIDS research has discriminated against women. This collection is a positive step in changing that tradition. I look forward to a follow up collection of research-based applications.

ROBIN FORBES is an opiate clinic therapist at the Centre for Addiction and Mental Health.

Women, Drug Use and HIV Infection, eds. Sally J. Stevens, Stephanie Tortu, Susan Coyle, The Haworth Press Inc., Binghamton, New York, 1998.

Negotiating the system

In the consumer/survivor community, Virginia S. Wilson is a "survivor." She believes that mental illness is an illness, in that people don't have a choice in the affliction. She hopes to help people with their first exposure to the mental health system and their first inpatient experience, in her debut how-to manual, *Mental Illness: Survival and Beyond*.

Wilson readily admits that her counsel for long-term stays in psychiatric facilities may not apply in the quick-fix 90s. But her vivid description of delirium following lateral electroconvulsive therapy — she believed she was covered "in black jellyfish that smelled like old running shoes" — and her counsel for preparing to leave the hospital and rejoining the "normal" world are practical support from a peer.

Being a consumer/survivor myself, I appreciate the blocked, bold text of clear directive in each of the opening sections of Wilson's book. In fact, writings from my period of hospitalization show that this type of highlighted prose would have been crucial to my comprehension in my heavily medicated state. Wilson is to be applauded for employing this technique, fleshing out

these tips with more detailed explanations.

Wilson gives a textbook overview of the medications that treat many major mental illnesses, descriptions of drug types, brand name and common side-effects, which rivals many drug manuals I have seen. Although her self-help advice for support mechanisms is rather intimidating and imperialistic — she discusses developing an "arsenal" and "mobilizing the troops" — the terms do grow on you, and encapsulate for the new "survivor" the concept of a strong support network, preferably in the community.

In her how-to "book," Wilson makes reference to another "book" that she says "provides much of the information [consumer/survivors] need" with its listing of resources. I wholeheartedly agree that *Making Choices*, published by Community Resources Consultants of Toronto, fulfills this need. It is nice to see a familiar benchmark discussed by a peer.

Although the relevance of a long-term inpatient experience may be questioned in the Common Sense Revolution era of health care, Wilson has prepared throughout her anecdotal narrative a practical guide to the "in's" of the mental health system that will help the consumer/survivor get "out."

CHRIS WHITTAKER is executive director of the Consumer/Survivor Information Resource Centre of Toronto.

Mental Illness: Survival and Beyond, Virginia S. Wilson, Trafford Publishing, Victoria, B.C., 1998, 90 pp.

Also Noted...

Standards and Guidelines for the Psychotherapies

Ed. Paul Cameron et al, University of Toronto Press, 1998

A reference book that defines and offers treatment guidelines for different types of psychotherapies, written by Canadian experts. Gender and cultural issues, training standards and record-keeping are also considered.

Antisocial Behaviour by Young People

Michael Rutter et al, Cambridge University Press, 1998

Co-written by one of the world's most respected authorities on child development, this volume reviews international research explaining antisocial behaviour, and also includes information on prevention and interventions.

The Last Word

Workplace smoking A time bomb?

BY ALWYN ROBERTSON

DRUG USE IN THE WORKPLACE IS A SITUATION FRAUGHT with legal and ethical implications. Smoking in the workplace, though, is also a drug issue fraught with personal and political implications.

People might think this issue is no longer a big deal. Smokers can always go outside or to the smoking room on their break. However, as more workplaces become smoke-free, people continue to smoke. This results in human costs that have not been considered in policy or legislative processes.

Let's think about what's really happening with smoking in the workplace, the theme chosen by the Council for a Tobacco-Free Ontario for National Non-Smoking Week on January 18 to 24.

In Ontario, work sites are covered by the *Smoking in the Workplace Act*, which prohibits smoking, but allows employers to designate smoking areas of up to 25 per cent of the enclosed work space. The problem is, the act does not specify that these areas should be separately enclosed or ventilated. While it's simpler to make all workplaces smoke-free, as evidenced by more stringent municipal by-laws, a mish-mash of "protection" for workers exists across Ontario. Why is this a time bomb?

A Gallup survey taken in Britain in 1998 "found 48 per cent of non-smokers believed colleagues who smoked did less work, with almost the same proportion believing pay cuts should cover smoking breaks." What would be the results here? Not only is the number of smoke-free workplaces increasing, more and more job ads clearly indicate that smoking is not permitted. This sets up a dilemma for both employers and employees. The best candidate may be a smoker, but company policy does not allow smoking.

We constantly see, outside office buildings, hospitals and any other workplace, groups of smokers huddled together in the worst weather conditions, having their version of nicotine replacement therapy.

A Conference Board of Canada study in 1997 conservatively estimated that the annual cost of a smoking employee, in 1995 dollars, was \$2,565, broken down into costs of increased absenteeism, decreased productivity, increased life insurance premiums and construction and maintenance of smoking areas. Tellingly, the largest cost was in decreased productivity through sick days and early death. This issue has to be faced by players in all sectors of the economy.

Here's another aspect of the time bomb. The next generation of workers, the students, are going to be working in smoke-free workplaces. How do they, and their prospective employers, deal with their addiction? The Ontario Student Drug Use Survey, conducted by the Centre for



We welcome submissions from our readers for opinion pieces. For information, contact the Editor, *Journal of Addiction and Mental Health*, 33 Russell St., Toronto, Ontario M5S 2S1; tel. (416) 595-6714; e-mail <adubey@arf.org>.

Addiction and Mental Health, indicated that 26 per cent of males and 29 per cent of females smoked occasionally. Rates are considerably higher in northern Ontario. Smoking on school property, a work site for students and teachers, continues to be problematic in some areas.

The *coup de grace* is that the price for a package of cigarettes in Ontario is the lowest in Canada and among neighbouring U.S. states. Governments are aware that price is a major factor in youth smoking. Governments are also aware that smoking rates are higher in lower income groups with lower education levels. The cost is a major factor in attracting new, young smokers and keeping existing users.

Employers need to go further than just having smoke-free workplaces while tolerating employees who are spending time smoking off-site. Even a designated, separately ventilated smoking area is a band aid.

Workplace smoking cessation programs and assistance for nicotine replacement therapy or counselling will go a long way. Not every employer can, or is willing, to offer such employee assistance programs, but why not have some type of tax credit system so that some of these costs can be reduced?

Where the lack of consistent regulations does not adequately protect workers from second-hand smoke, employees should take the issue in hand. It can be done. In Windsor-Essex, a municipal exemption from the workplace smoking act for manufacturing facilities, especially affecting auto workers, has been successfully amended because of pressure from the employees and the union.

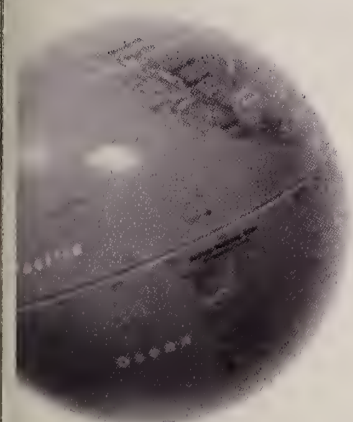
This case illustrates the need to have clearly enforced and uniform standards throughout the province. It also shows that people are beginning to understand the impacts of second-hand smoke. Combined with environmental chemicals and other production hazards, the health effects are multiplied in some industries.

What about cessation? A recent Angus Reid survey indicated that 64 per cent of smokers are "concerned about their smoking and would like to quit." Perhaps encouraging more self-help groups, in addition to OHIP-approved drug benefits for cessation, would help the smoking population that has the greatest need.

The bomb is still ticking, and we need to defuse it. Those of us in the tobacco control community see the evidence every day and can project where it might lead. The challenge is to keep this on our collective agenda, with the goal of crossing it off before the next millennium becomes too old. ■

Alwyn Robertson is executive director for the Council for a Tobacco-Free Ontario. The views expressed here are her own.

Conferences



CANADA

Injection Drug Use -- Societal Challenges

March 12-14, Montréal, Québec.
Contact: Bureau des Congrès Universitaires, Injection Drug Use, 3333, chemin Queen-Mary, bureau R-320, Montréal, PQ H3V 1A2, tel (514) 340-3215, fax (514) 340-4440, e-mail <bureau@congrescu.com>.

Global Issues in a Global Village: Local, National and International Perspectives

April 15-16, Toronto, Ontario. Contact: Debby Vigoda, Ontario Gerontology Association, 351 Christie St., Toronto, ON M6G 3C3, tel (416) 535-6034, fax (416) 392-4157.

Community and Treatment -- "Shared Responsibility"

April 22-24, 1999, Ottawa, Ontario. Contact: Canadian Foundation on Compulsive Gambling, tel (416) 499-9800, fax (416) 499-8260, e-mail <cfcg@interlog.com> (bilingual conference).

Alternatives to Attention Deficit Disorder-Children are First Training Series

April 22-23, 1999, Toronto, Ontario. Contact: Brief Therapy Training Centres-International, 114 Maitland St., Toronto, ON M4Y 1E1, tel (416) 972-1935, ext. 3345, fax (416) 924-9808, e-mail <hincks@interlog.com>.

National Conference on Best Practices and Mental Health Reform

April 31- May 1, Toronto, Ontario. Contact: Catherine Riley, conference co-ordinator, Centre for Addiction and Mental Health, tel (416) 979-6963, fax (416) 979-4970.

Interprovincial Conference on Fetal Alcohol Syndrome

May 4-7, Calgary, Alberta. Contact: Lyne Callan, Conference Program Committee; AADAC Training and Communications Services, 3rd Floor, Stephenson Building, 1177-11 Avenue S.W., Calgary, Alberta T2R 0G5, tel (403) 297-3019, fax (403) 297-3020, e-mail <lyne-callan@aadac.gov.ab.ca>.

International Conference on FAS/FAE: Uncovering the Mysteries of Fetal Alcohol Syndrome: Is There Hope?

May 5-7, 1999, Lethbridge, Alberta. Contact: Tamara D. Hanoski, Family Care, Ltd., 1256 3rd Ave. S., Lethbridge, Alberta T1J 0J9, tel (403) 320-1399, fax (403) 327-6337.

Troublesome Children & Juvenile Offenders -- Institute for the Study of Antisocial Behaviour in Youth

May 6-7, Toronto, Ontario. Contact: Education and Training, Centre for Addiction and Mental Health, tel (416) 595-6020, fax (416) 595-6644.

Anxiety and Dysthymia

May 7, Winnipeg, Manitoba. Contact: University of Manitoba, tel (204) 789-3360, fax (204) 789-3911.

Healthy People and Healthy Community: A Canada-US Dialogue on Best Practices in Public Health

May 8-9, Toronto, Ontario. Contact: Carey Hill, The Canada West Foundation, 550-630 3rd Avenue SW, Calgary, AB T2N 1N4, tel (403) 264-9535, fax (403) 269-4776, e-mail <hillca@ucalgary.ca>.

Annual Meeting of the Canadian Association of Psychosocial Oncology

May 13-15, Edmonton, Alberta.

Contact: University of Alberta, tel (403) 492-6346, fax (403) 492-5487.

Canadian Psychological Association Annual Convention

May 20-22, Halifax, Nova Scotia. Contact: Kathy Lachapelle-Petrin, tel (613) 237-2144 ext. 30 or 1-888-472-0657, fax (613) 237-1674, web <www.cpa.ca/halifax>.

Canadian Public Health Association 90th Annual Conference

June 6-9, Winnipeg, Manitoba. Contact: CPHA Conferences, 400-1565 Carling Ave., Ottawa, ON K1Z 8R1, tel (613) 725-3769, fax (613) 725-9826, web <www.chpa.ca>.

9th Canadian Social Policy Conference

June 20-23, Montréal, Québec. Contact: Céline Beauchemin, École de service sociale, Université de Montréal, CP6128, Succ. Centre-ville, Montréal, PQ H3C 3J7, tel (514) 343-6596, fax (514) 343-2493.

AIDS Impact 1999 -- Biopsychosocial Aspects of HIV Infection

July 15-18, Ottawa, Ontario. Contact: Canadian Psychological Association, 205-151 Slater St., Ottawa, ON K1P 5H3, tel (613) 237-2144, fax (613) 237-1674, web <www.aidsimpact.com>.

National Association of Dual Diagnosis (Developmental Disability and Mental Health Needs) Annual Conference

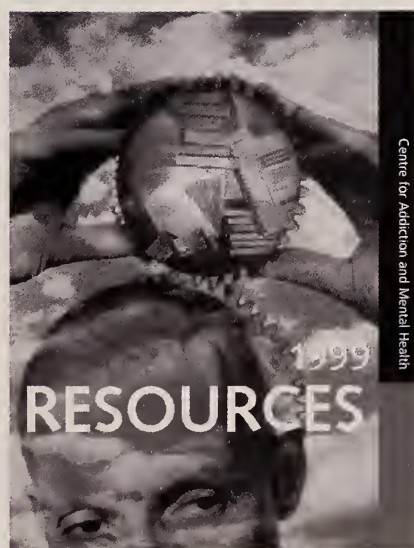
Nov. 10-13, Niagara Falls, Ontario. Contact: tel (914) 331-4336, e-mail <nadd@ulster.net>, web <www.thenadd.org>.

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March 14-17, New Orleans, Louisiana.
Contact: American Association for
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**International Congress on
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April 17-21, Santa Fe, New Mexico.
Contact: International Congress on
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Coordinators, Maryland Psychiatric
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e-mail <icosr@umaryland.edu>.

Women and Children in Treatment

April 23-24, 1999, Sarasota, Florida.
Contact: National Acupuncture Detoxi-
fication Treatment, 3220 N Street NW
#275, Washington DC 20007, fax (805)
969-6501, e-mail <AcuDetox@aol.com>.

**30th Annual Medical Scientific
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ABROAD

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March 7-12, Les Diablerets, Switzer-
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Swiss Institute for the Prevention of
Alcohol and Other Drug Problems
(SIPA), C.P. 870, CH-1001 Lausanne,
Switzerland, tel 41 21 321 295 5,
fax 41 21 321 29 40, e-mail
<hklingemann@sfa-isp.ch>.

**International Forensic Mental
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March 17-19, Melbourne, Australia.
Contact: The Conference Organiser Pty

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**10th International Conference
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March 19-22, Geneva, Switzerland.
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e-mail <hrc@hit.demon.co.uk>, web
<www.ihra.org.uk/geneve>.

**International Conference on
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April 27-29. London, England. Contact:
Eating Disorders '99, Mark Allen Inter-
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Mews, 286A-288 Croxted Road,
London SE24 9BY, England, tel (44) 181
671-7521, fax (44) 181 674 4550.

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June 12-17, 1999, Acapulco, Mexico.
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**38th International Congress on
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Aug. 16-20, Vienna, Austria. Contact:
International Council on Alcohol and
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<www.icaa.ch>.

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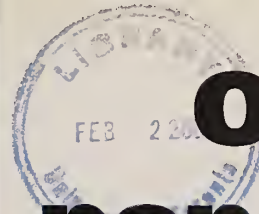
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May/June
1999
Volume 2
Number 3



Our aging population

Substance use,
addictions and the elderly

Male menopause
can hormone replacement
treat depression?



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FETAL ALCOHOL SYNDROME

Moderation vs. abstinence

EDMOND YU INQUEST

Jury makes
recommendations

THE HEALTH EFFECTS OF CANNABIS

Book review



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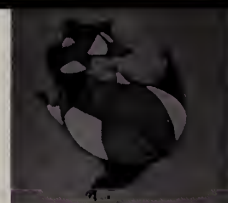
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Cover

"Dancing Rat"
by Jes Donovan
pen and watercolour on paper



Jes Donovan, from Owen Sound, is a first-year design student at Humber College in Toronto. She finds art and music to be her best means of expression. Of the figure in this painting, she says, "He's just a character I really like. I always found that I wanted to be an animal more than I wanted to be a human; their lives seem so much more interesting."

News from the Centre

AT ITS APRIL MEETING, the Board of Trustees of the Centre for Addiction and Mental Health enthusiastically approved *Future Directions: the Final Report on Strategic Planning*. Trustees were extremely supportive of the process by which the Strategic Plan was developed. Extensive consultations were conducted in order to develop a mandate reflecting the need and vision for the Centre. With input from almost 1,000 individuals to *Future Directions*, the Centre can move forward with confidence in its mandate. The full report is available by calling the Centre at 595-6878, and can be seen on the Centre's website at <www.camh.net>. Teams, headed by each of the senior managers, will implement the strategic directions.

Next steps will move the process to the program level, where programs will be examined against the strategic directions. The implementation process will include a wide range of evaluation mechanisms as well as regular opportunities for stakeholder input. The Board and Centre staff are very pleased that the *Final Report on Strategic Planning* for the Centre for Addiction and Mental Health is well thought-through, informed by those who use, provide or work with the services, and has the support of internal and external partners. It is a document that will help up to move forward to the next level of building a resource that is valuable to and valued by the people the Centre serves.

In other developments, the Centre's internationally renowned, ground-breaking work has

been recognized by the World Health Organization (WHO). This spring, the WHO designated the Centre as a Centre of Excellence in Addictions and Mental Health — one of only four in the world. Internationally, this designation recognizes the Centre as leading edge and will bring world attention to its advances. On a national level, Canadians will watch world-class expertise and knowledge collaborate to produce practices to dramatically improve the capacity and quality of Canada's mental health and addictions systems of care.

In late March, the Centre underwent its first-ever accreditation survey and in early May received full Accreditation. The surveyors from the Canadian Council on Health Services Accreditation were extremely impressed with the level of care provided by Centre staff, the clear commitment to assess and improve the quality of work, and the effort to aspire to excellence in building the foundation for the new Centre. They praised the Centre's programs as being client-centred, reflecting strong collaboration and an ongoing quest for excellence. They commended the Centre's merger strategies, saying, "you could teach others how to integrate, based on your own efforts." They were particularly impressed with the Centre's continuous quality improvement initiatives and its "balanced scorecard," and remarked that "quality improvement seems to be an attitude ... a part of the culture of the Centre."

BY RENA SCHEFFER

Downloaded

Are mental disorders as common in women as in men?

The *Mental Health Supplement* to the 1990 Ontario Health Survey indicates that females aged 15 years and older are almost 1.5 times more likely than males in the same range to experience a mental disorder in their lifetime.

This is just one of the many informative FAQs (Frequently Asked Questions) answered on the CMHA (Canadian Mental Health Association) Ontario Division Web Site:<<http://www.ontario.cmha.ca>>. The array of questions and the quality of answers, which are referenced, is impressive.

In fact, the whole site is impressive. To increase your awareness of mental health issues and strategies in Ontario, check this web site routinely. From statistics to the latest key reports, it's a sure bet for keeping you informed and up-to-date. Visitors even have access to an e-mail alert service; see the **Auto-Alert** on the main page and simply fill in your e-mail address.

Correction: In the previous *Downloaded* (March/April 1999), the Web address for the National Guideline Clearinghouse should be: <<http://www.guidelines.gov>>.

SHEILA LACROIX

Letters



Dr. Raju Hajela
c/o The Journal of
Addiction and Mental Health

Dear Dr. Hajela,

It is a great pleasure to read the article titled "Bring spirituality into treatment, MD says" written by Craig Smith in the December 1998 issue of *The Journal of Addiction and Mental Health*.

Our organization, Operation Dawn, founded 31 years ago, aims to provide a Christian Therapeutic program for drug addiction. We used the approach coined as Trinitarian Total Man Cure in which we highlight mainly on the spirituality realm of rehabilitation of the individual.

At present, our work has been expanded to Tai Wan, Thailand, India and Myanmar.

You are cordially invited to visit our work in Hong Kong, as well as those branches in Asia. Please let me know if you are interested.

Hoping that we might be able to co-operate and work together to promote the concept of bringing spirituality into treatment in the near future.

Yours Sincerely,

John Paul Chan (Rev.)
International Director
Operation Dawn
311D Prince Edward Rd.
G/F. Kln. Hong Kong

Letters to the editor are welcome. They must be signed and include a daytime telephone number. Letters may be edited to fit space.

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In Brief

Students and inhalants

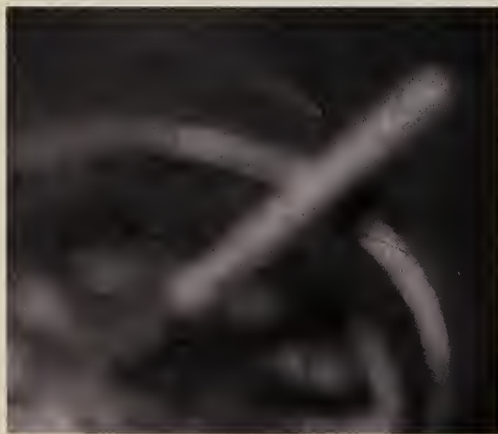
According to data from the 1997 Ontario Student Drug Use Survey, 3.2 per cent of all Ontario students report using at least one inhalant during the year prior to the survey. Inhalant use is highest among Toronto students, compared to students in other regions. The survey data were based on students who reported inhaling glue, paint thinner or polish remover during the past year.

WHO outlines trends, challenges

The World Health Organization (WHO) held its 103rd session in Geneva, Switzerland in January. Drs. Julio Frenk and Chris Murray gave a presentation called *Trends and Challenges in World Health*. They proposed that by 2020, the leading causes of the burden of disease will be heart disease, depression and road traffic accidents. They predicted that the aging population, the HIV epidemic, and tobacco-related mortality and disability would influence health trends.

Smoking issue heats up Toronto

The debate over a proposed smoke-free bylaw began again in April in Toronto, the *Toronto Star* reports. Advocates for a ban on smoking believe that the proposed new regulations are not tough enough. Spokespersons for the food service industry, however, argue that bar and restaurant owners should be allowed to regulate smoking for their own clientele. The public health department recommends that all the city's restaurants and bowling alleys either be smoke-free by April 30, 2001, or have smoking restricted to enclosed areas. The city's council plans to vote on the new bylaw June 29.



Screening for teen suicide risk

Better treatment and diagnosis of depression, anxiety disorders and substance abuse can help reduce the risk of suicide in youth. The study, published in *The Journal of Clinical Psychiatry's* March supplement, states that direct, confidential screening of high school students for risk factors, including previous suicide attempts, suicidal thoughts, and substance abuse, have proven effective in identifying at-risk teens whose problems may be hidden from others. Suicide is the third leading cause of death among American adolescents aged 15 to 19. About 90 per cent of teenagers who commit suicide have a mental illness. The highest-risk teens are boys aged 17 to 19 who drink heavily.

Prozac questioned

A new report on antidepressants finds that Prozac and other newer antidepressant medications are no better or worse than older antidepressant drugs. According to *The Globe and Mail*, the Agency for Health Care Policy and Research of the U.S. Department of Health and Human Services, which prepared the report, cautions physicians that not enough research has been done to establish whether the drugs are effective in the treatment of children and patients with mild forms of depression.

Wine drinkers and heart disease

The connection between wine drinkers and lower rates of heart disease may be partly explained by healthy lifestyle, rather than wine consumption. According to a report in the *American Journal of Public Health*, a study on men aged 40 to 59 indicated that those who were wine drinkers tended to be light drinkers, have low rates of smoking and obesity, work in non-manual jobs, and were more likely to be physically active than those who consumed other types of alcohol.

Secondhand smoke and pregnancy

Researchers at the University of Louisville find that exposure to secondhand smoke may pass cancer-causing chemicals to the fetuses of pregnant women, Reuters reports. The researchers studied 475 pregnant women, and found that levels of harmful chemicals were higher in the umbilical cords of both smokers and nonsmokers exposed to secondhand smoke. After they are born, the children will be monitored over the years to see if they are more likely to develop emphysema, asthma, coughing, and overall rates of hospital admission.

DON BARRIE



Young smokers face genetic damage

People who smoke during adolescence have a greater risk of genetic damage than those who start later in life. According to a study published in *The Journal of the National Cancer Institute*, young bodies are more sensitive to genetic damage from smoking tobacco. Researchers examined the lungs and the blood of 143 lung cancer patients for cells carrying evidence of DNA damage.

Stress and pharmacists

The Pharmacy Association of Nova Scotia (PANS) is helping pharmacists deal with stress with a booklet called "Take Five," *Canadian Healthcare Manager* reports. Citing long shift hours, and the need to deal with health plan administrative tasks, PANS members named stress as their number one issue in a past survey. The booklet examines the causes of stress among pharmacists, looks at the psychology and physiology of stress, offers suggestions for dealing with stress, and includes a self-test that allows pharmacists to determine their own stress level.

Feminist therapy leaves women empowered

Following feminist therapy, clients are better equipped to cope with challenges in their environment, according to a recent study by Dr. Judith Worell and her associates at the University of Kentucky.

This finding was based on a follow-up evaluation of 18 clients one year after they had participated in feminist therapy, some for no more than three sessions and others for more than seven. In their initial assessment, the researchers found that the more the therapists used feminist strategies, the higher the women rated on scales measuring well-being and empowerment. However, one year later, the well-being did not increase but the empowerment increased significantly.

"This finding suggests that the therapy was not only helping them to feel better, but had increased their skills in dealing with their environment; thus, they still had many of the problems in living that brought them to therapy, but felt more competent and self-confident that they were able to cope with these problems," says Dr. Worell. The longer the clients stayed in therapy, the more likely they were to say that they remembered the feminist principles and carried them with them.

"Traditional therapy regards improvement as symptom reduction, while feminist therapy

says that if we just try to reduce symptoms, we are still returning that person to an environment that may be unhealthy or toxic: a woman needs strategies not only to change aspects of herself, but to help her deal more effectively with her environment," says Dr. Worell. She assesses empowerment according to a model she developed, measuring such variables as gender and cultural awareness, perceived sense of personal control, assertiveness and problem-solving skills, and flexibility or openness to alternatives.

The study began in 1997, when 15 counsellors from eight university counselling centres agreed to participate in the study, which included giving a packet of questionnaires to the first four female clients who walked in their office. While the only requirement was that the counsellors provide psychotherapy to women, Dr. Worell found it interesting that all 15 counsellors who volunteered scored relatively high in a scale measuring their feminist orientation. Their feminist orientation was confirmed both by their scores on this scale, and from what clients described as having experienced. A total of 45 of a potential 60 clients responded to the initial questionnaire, while only 18 of the original 45 were able to be followed up one year later.



Photo: Diana Ballon

Dr. Brenda Toner (L) and Dr. Judith Worell

The next step will be to compare outcomes of feminist therapy against other forms of psychotherapy, Dr. Worell says. Consistent with these suggestions, Dr. Brenda Toner, head of the Women's Mental Health Research Program at the Centre for Addiction and Mental Health, says that her program is committed to systematically testing the efficacy of feminist therapy against other forms of psychotherapy. As well, they are "currently working with Dr. Worell, both at a local and international level, to develop process and outcome measures that assess the efficacy of integrating feminist principles into therapy with women," says Dr. Toner.

Dr. Worell is currently revising her 1992 book, *Feminist Perspective in Therapy: An Empowerment Model for Women*, which she co-wrote with Dr. Pam Remer.

DIANA BALLON

Sleep disturbances studied in alcoholics

For years, it seemed to be inconsequential that people who snore, particularly men, snore more after drinking — until obstructive sleep apnea (OSA) was discovered.

OSA, characterized by periods of airway narrowing or closure during sleep, leads to sleep disruption and daytime sleepiness.

Drinking in the evening leads to upper airway narrowing and increased snoring. A recent study conducted at the University of Michigan, Ann Arbor, has now found that sleep apnea and related disorders also contribute to sleep disturbances in abstinent alcoholics.

The study on sleep-disordered breathing (SDB), led by Michael S. Aldrich, Kirk J. Brower and Janette M. Hall, surveyed a sampling of 103 abstaining alcoholics and a comparison group of 87 normal subjects. The abstinent alcoholics in the study were undergoing treat-

ment for alcoholism. Polysomnography and questionnaire data were used to detect the presence of SDB.

Previous studies had shown that apnea was common in older male alcoholics.

Of the sample tested, the abstaining alcoholics demonstrated SDB in three per cent of subjects under age 40, 17 per cent of subjects aged 40 to 59, and 50 per cent of subjects aged 60 or over.

Researchers found that subjects with SDB were more likely to be male, had more severe sleep disruption, and were more likely to complain about daytime sleepiness than subjects without SDB. Age and body mass index were seen as significant predictors of the presence of SDB, but not smoking history and duration of heavy drinking.

Researchers conclude that SDB contributes



significantly to sleep disturbance in a substantial proportion of older alcoholics, and that symptomatic SDB increases with age in alcoholics. SDB, when combined with existing cardiovascular risk factors, may contribute to adverse health effects in alcoholics. DON BARRIE

Courage to Come Back awards given

BY CHRISTA L. HAANSTRA

Seven extraordinary Ontarians were celebrated on May 6th, 1999, when the Centre for Addiction and Mental Health Foundation held its annual Courage to Come Back awards dinner. Each year the foundation awards people who have recovered from life-threatening illness, injury or addiction, in seven different categories: physical injury, general medical illness, chemical dependency, celebrity, mental illness, youth (18 and under), and seniors (65 and older).

Just a few years ago, George Panagapka was using drugs and living on the streets. Despite his misfortune, he fought for the good of his community. Today, he is no longer using drugs and has a place of his own. He has returned to Parkdale, the Toronto community that used to be the locus of his life, where he volunteers with community organizations, and is working to better the lives of others living on the streets and using drugs.

Elinor Dumbreck continues to fight back after sustaining serious injuries in a car accident five years ago. Today she inspires others who are facing similar situations through her public speeches about her miraculous recovery.

After suffering from his third stroke in five years, Jerry Mitchell hopes that, through continued therapy, he will be able to coach his daughter's soccer team again this summer. Also living with an amputation of his left arm below the elbow and the middle fingers of his right



The 1999 Courage to Come Back winners at the awards dinner

hand, and sarcoidosis, an auto-immune disease that causes other serious health problems, Jerry has shown his courage to all around him and continues to contribute to his community by volunteering with many organizations.

At 13, Nicole Rektor has already lived through over 35,000 seizures. She amazes everyone with her ability to enjoy life. At a recent community fund-raiser, Nicole did media interviews to help raise awareness of epilepsy, and helped raise over \$33,000.

Marjorie Flynn has always enjoyed helping others. Even though Marjorie sustained injuries while caring for her husband who had Alzheimer's disease, she continued to care for him at home until three months before his death. Now 82, she has recently been diagnosed with osteoporosis, but she continues to have a positive impact on others by, among other things, baking muffins for a breakfast program for children from low-income families, and sharing her goodies with her neighbours.

Following his diagnosis of schizophrenia, Gordon Singer was hospitalized more than 15 times in a period of 17 years. In 1993, he finally

found a new treatment that worked for him. With this new medication and psychosocial rehabilitation, he began his reintegration into society. Committed to reducing the stigma for those living with mental illness, he has made numerous media appearances and volunteers with related community organizations.

Mark Leduc's lifestyle and addiction to cocaine eventually led to him to a life of crime. In 1984 he was convicted of armed robbery and sentenced to 6.5 years in prison. It was during his imprisonment that Mark re-entered the world of boxing. After a lot of hard work and dedication, Mark won a silver medal in boxing at the 1992 Olympics. Mark has spent time touring high schools, using his personal story to illustrate the dangers of drugs and peer pressure. He now works in the film industry and volunteers for the Toronto People with AIDS Foundation.

These phenomenal stories are an inspiration to all Ontarians. If you know someone who has had the Courage to Come Back and would like more information on next year's awards, please contact the Foundation office at (416) 979-6909.

Yu inquest delivers verdict

After nearly 11 weeks of investigation, a coroner's jury for the Edmond Yu inquest delivered its verdict on April 16.

Yu suffered from paranoid schizophrenia. He was killed by police in February 1997, after he slapped a woman on a TTC bus in Toronto.

The inquest examined issues such as Ontario's mental health system, mental health law, police training, police alternatives to deadly force, crisis resolution, diversity, housing, income and employment. The jury made 24 recommendations to 10 parties, including the Ministry of Health, the Toronto Police Service, the Ontario Police College, and the Ontario Psychiatric Association, Universities and College of Physicians and Surgeons.

In the verdict, the jurors state that they focused their recommendations on "those issues that will make a difference, hopefully effect change in a

positive manner and assist to prevent further tragedies from happening."

Crisis resolution training for police, and better use of available crisis teams by police, were recommended. The recommendations also include support and funding for Mental Health Law education, research into the cause and treatment of schizophrenia, ethno-specific psychiatric services, new and existing consumer-based employment initiatives and non-medical "safe-houses."

In their final recommendation, the jury concluded that, "It would be remiss of this jury not to comment on the issue of forced medication for those mentally ill persons who have a history of demonstrated dangerousness to the public.

"We feel strongly that the public must be protected. Failure to take corrective medication may require the law to be changed to state that the alternative would be involuntary hospitalization in a mental health facility."

SUE McCLUSKEY

Fetal alcohol syndrome

How much alcohol is too much?

BY CHRIS HENDRY

Though the basic trend in alcohol policy has been to recommend abstinence during pregnancy, there is a growing agreement that such policies err on the side of prudence.

The risk of damage to the fetus, described in fetal alcohol syndrome (FAS), a disorder characterized by behavioural abnormalities, developmental delays, growth deficiencies and facial abnormalities, and fetal alcohol effects (FAE), a serious disorder with some of the features of FAS, supports the argument for abstinence. However, while there is enough scientific information to justify warning against excessive drinking during pregnancy, there is insufficient research on moderate consumption of alcohol during pregnancy and the effect it might have on a developing fetus. In other words, we cannot yet set a threshold below which it is absolutely safe to the fetus for a pregnant woman to drink.

It is these two conflicting messages that make it difficult to articulate a single agreed-upon policy.

The editors of an International Centre for Alcohol Policies (ICAP) report, released in January, compared various low-risk drinking guidelines that different countries have set for women during pregnancy.

Looking at policies from Australia, Austria, Belgium, Canada, Denmark, France, Germany, Ireland, the Netherlands, New Zealand, Portugal, Spain, Sweden, Switzerland, the United Kingdom and the United States, they found that, even though the trend was toward abstinence, several of the countries surveyed (Belgium, France, Germany, the Netherlands, Portugal, Spain and Switzerland) had no official recommendations.

As ICAP paraphrases the British *Sensible Drinking Guidelines*, "In spite of increasing scientific work on women's drinking over the last ten years, there is still a less secure scientific literature from which to make conclusions about women as compared with men."



Michael Piercy, a program consultant with Community Health and Education at the Centre for Addiction and Mental Health, appreciated ICAP's survey both for its candour and for its possible use as a tool in getting this tricky message about alcohol policy across. He feels it is correct to recommend abstinence during pregnancy. However, given the fact that science hasn't been able to determine a threshold point below which no damage will occur, policy makers must tread a fine line between sound advice and causing undue anxiety in a woman who had been drinking between the time of conception and her first awareness of the pregnancy. He says that though there is no proven point below which it is safe to consume alcohol during pregnancy, it is most likely that an occasional drink will do no harm.

More importantly, Piercy says, ICAP's discussion of low-alcohol guidelines is part of a much larger picture. He notes that little thought is being given to other issues, such as the negative effects of consumption of alcohol during lactation; the role-modeling effect men, family and friends may have on the behaviours of a pregnant woman; whether or not information about FAE and FAS is readily available for women to make an informed choice about their drinking habits; and whether or not community resources are in place for women to seek treatment if they are concerned about their drinking.

Until such issues are considered, one universally agreed-upon policy on drinking during pregnancy is far from becoming a reality.

Report finds no change in illicit drug use in Toronto

Although there has been an increase in the number of youth seeking treatment for crack abuse, levels of illicit drug use in the general population of Toronto are relatively stable, according to *Drug Use in Toronto 1999*. The report, released by the Research Group on Drug Use, is the ninth in a series of annual reports that monitor illicit drug use in Toronto.

This year's report finds that, within the adult and student populations, there has been no noticeable increase in drug usage. "Nothing really striking; not much difference in one-year cycles," says Dr. Ed Adlaf, a researcher at the Centre for Addiction and Mental Health and one of the authors of the report.

Crack cocaine use is reported by fewer than one per cent of adults and two per cent of students. Based on information from outreach workers at The Works, a Toronto needle exchange program, crack seems to be the drug of choice for street youth. This could be because crack is both cheaper and more readily available than other drugs.

Although alcohol is not a focus of the study, half of the youth in treatment for either cocaine or heroin abuse also had problems with alcohol.

Heroin use is reported by less than one per cent of Toronto adults and less than two per cent of students. In 1994, when the purity of heroin

was high, there were 67 deaths associated with heroin use. The report found that, although the purity of heroin seized by the police has once again increased, the number of deaths has decreased slightly from 38 in 1996 to 36 in 1997. One reason for this decline, suggests Dr. Adlaf, could be the use of methadone treatment by heroin users. The increase in purity, combined with the decrease in deaths, is a "little bit of a blip," says Dr. Adlaf. "It's unexplained right now." It won't be for another year or two, when future statistics are compiled, that any kind of a trend could be determined.

The yearly report documents and monitors trends in drug use and in so doing, compares Toronto with other geographical locations. The Research Group on Drug Use hopes, in the future, to report on continuing efforts of prevention, education and treatment.

Information for this year's report was gathered from eighteen organizations, including the Toronto Public Health Department, the Toronto Police Services, the Office of the Chief Coroner of Ontario, the Drug and Alcohol Registry of Treatment as well as the Centre for Addiction and Mental Health.

Drug Use in Toronto 1999 is in the public domain. Look for it on-line by early June at <city.toronto.on.ca> or <drugctr@city.toronto.on.ca>.

DOLORES SEDORE

Research Update

Drinking and female sexuality

In a structured diary study, 97 Finnish women (including both oral contraceptive users and nonusers) aged 18 to 35 years were asked to monitor "sexual feelings and alcohol intake during one menstrual cycle." It was found that consumption of alcohol was "significantly associated with elevated sexual interest and arousal in the post- and intermenstrual phases." Though a positive relationship between drinking and sexual arousal had been established under laboratory conditions, this was one of the first field studies to convincingly show covariance.

Alcoholism: Clinical and Experimental Research, vol. 23, no.1: 169-173. Ralf E. Lindman et al., Department of Psychology, Abo Akademi University, Helsinki, Finland.



Weak link between marijuana and crashes

Consumption of marijuana alone and in moderate amounts does not significantly increase a driver's risk of causing accidents. Alison Smiley, a researcher at the University of Toronto, found that though marijuana does impair driving ability, its users are often more aware of their impairment than drunk drivers and are able to compensate accordingly. Says Smiley, users of marijuana exhibit behaviours "more appropriate to their impairment, whereas subjects who receive alcohol tend to drive in a more risky manner."

The Health Effects of Cannabis, eds. Harold Kalant, W. Corrigal, W. Hall and R. Smart, Centre for Addiction and Mental Health, Toronto, Ontario, 1999.

Treating mood disorders in addicts improves both conditions

In a recent National Institute on Drug Abuse study, researchers discovered that treating drug-dependent teenagers with lithium (a substance commonly used in the treatment of bipolar disorder) reduced drug use. In a double-blind, placebo-controlled study involving 25 teenagers with a history of drug abuse and mood disorders, researchers found that "lithi-

um treatment for the manic phase of bipolar disorder also reduces drug and alcohol dependence." For a large portion of people with drug dependencies, mood disorders such as bipolar disorder appear concurrently.

NIDA Notes, vol. 13, no.6: 6 & 11. Barbara Geller et al., Washington University, St. Louis.

Connection between addictive behaviours and depression found

Starting to smoke at a young age is as predictive of alcohol and drug use as it is of someone developing depressive disorders. A survey of 42,862 Americans found that participants who had begun smoking before the age of 13 were "more likely to have a family history positive for alcoholism, be current smokers, and smoke more per day [and were more likely] to receive diagnoses of depression at a younger age." It was also found that irrespective of age, smokers were more likely to use illicit drugs and be diagnosed with a major depressive disorder at some point during their lives with the greatest risk of drug dependence being for those who began smoking before the age of 16. These findings lend credence to the theory that there is "a common factor involved in addictive behaviours and depression."

Alcoholism: Clinical and Experimental Research, vol. 23, no. 3: 513-522. Eleanor Z. Hanna and Bridget F. Grant, National Institute on Alcohol Abuse and Alcoholism, Rockville, Maryland.

Smoking clouds good judgment

In a recent telephone survey of 3,031 Americans that included 737 current smokers, perceived risk of harms associated with smoking was analyzed. Though cigarette smoking is known to cause more preventable deaths due to cancer or cardiovascular disease than any other modifiable risk factor, this study found that "only 29 per cent and 40 per cent of current smokers believed they have a higher-than-average risk of [heart attack] or cancer, respectively." In the survey, researchers also found that "only 39 per cent and 49 per cent of heavy smokers acknowledged these risks" of heart attack and cancer. Researchers at the Brigham and Women's Hospital and Harvard Medical School were able to conclude that most Americans who smoke do so without recognizing the increased personal risks they run.



The Journal of the American Medical Association, vol. 281, no.11: 1019-1021. John Z. Ayanian et al., Harvard Medical School, Boston, Massachusetts.

Little gender bias in incidence of ADHD

In a recent study involving almost 3,500 children, researchers at Washington University School of Medicine in St. Louis discovered that boys were four to nine times more likely to be diagnosed with attention-deficit/hyperactivity disorder (ADHD), but that "inattention problems are just as common in girls as in boys, and just as impairing." According to Rosalind J. Neuman, Ph.D., research assistant and lead author of the study, though "young boys are more likely than girls to receive treatment for hyperactivity, simply being female does not reduce the risk of ADHD." Psychiatrists and psychologists traditionally classify ADHD as belonging to one of three types, defined by inattention or distractibility, hyperactivity and



impulsivity, and a third form involving problems in both areas. The children in this study provided evidence for only two of those subtypes.

Journal of the American Academy of Child and Adolescent Psychiatry. Rosalind J. Neuman et al., Washington University School of Medicine, St. Louis, Missouri.

Genes influence women's caffeine use

The impact of genetic factors on caffeine consumption has been largely unknown, though caffeine is by far the most commonly used psychoactive substance. Researchers at the Medical College of Virginia/Virginia Commonwealth University and the Virginia Institute for Psychiatric and Behavioral Genetics assessed 1,934 individual female-female twins (including members of identical and non-identical sets of twins) for patterns of caffeine consumption. They found that, while there was no evidence that family environment contributes to twin resemblance for caffeine intake, identical twins exhibit resemblance in caffeine consumption that is substantially greater than that of non-identical twin

pairs. They estimate the heritability of caffeine toxicity, tolerance and withdrawal at 35 to 45 per cent, and the heritability of heavy caffeine use at 77 per cent. Researchers conclude that addiction to caffeine demonstrates a pattern similar to that of other licit and illicit drugs, where individual use, intoxication, tolerance and withdrawal are substantially influenced by genetic factors.

American Journal of Psychiatry, vol. 156, no. 2. Kenneth S. Kendler and Carol A. Prescott, Medical College of Virginia/Virginia Commonwealth University and the Virginia Institute for Psychiatric and Behavioral Genetics, Richmond, Virginia.

Higher doses of methadone effective and safe

In a study sponsored by the National Institute on Drug Abuse, researchers from the John Hopkins University School of Medicine reported that "methadone can be used safely at dose levels higher than those often considered standard, and that the higher dosages significantly improve treatment outcomes." Though methadone has been used for decades in the treatment of opiate addictions, its "optimal" dose has never been agreed upon. Whereas prescribed doses of methadone are often as low as 20 to 30 mg/d, Dr. Eric C. Strain, lead author of the report, says, "we found that methadone treatment, even over a very broad range of doses, significantly improves clinical outcomes for opiate addicts. But some addicts may need doses in excess of 100 mg/d."

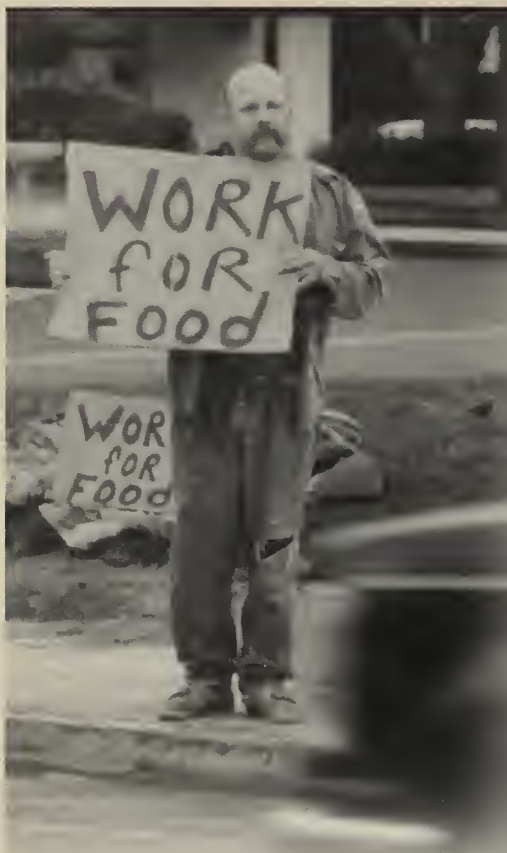
The Journal of the American Medical Association, March 17, 1999. Eric C. Strain et al., John Hopkins School of Medicine, Baltimore, Maryland.

Cognitive scale for functional bowel disorders

Researchers in the Women's Mental Health Program at the Centre for Addiction and Mental Health have developed a cognitive scale for functional bowel disorders (FBD). Though the importance of physiological factors in clients with FBD has been established, this scale represents the first time psychosocial measures were designed and validated with an affected population. The Cognitive Scale for Functional Bowel Disorders reflects the distillation of responses of 75 FBD patients from Canada and the United States who were asked to rate 95 areas where FBD interfered with their lives. The scale will be used "as an outcome measure in evaluating the efficacy of different forms of psychotherapeutic intervention for FBD, and [will] also serve as a helpful assessment tool."

Psychosomatic Medicine, no. 60. 492-497. Brenda B. Toner et al., the Centre for Addiction and Mental Health, Toronto, Ontario.

CHRIS HENDRY



Bringing health care to homeless people

Shared Care Program delivers services in shelters, hostels, drop-ins

BY SUE McCLUSKEY

Such compliance is achieved through the non-coercive approach of the Shared Care team. Team members work at the host site, where they can establish relationships with clients, assess their health care needs, and ensure that treatment is received. Though each team is customized, most at present consist of a full-time nurse and outreach worker, a part-time salaried general practitioner and a consulting psychiatrist.

Cynthia Karlton, of the Centre for Addiction and Mental Health, is the Shared Care Program's co-ordinator. She notes that on-site delivery of

not the only need that the Shared Care teams could serve. Staff now find in many cases that they also act to reconnect clients with other services in the community.

Nancy Scott, a shared mental health care nurse, is responsible for both primary care and mental health care at the Seaton House office. She says that part of the work of her team is "trying to pull services in from all different directions.... In order to get somebody housed, they have to have money. In order to get money, they have to get ID. In order to get ID, they have to have proof of citizenship, and on and on and on it goes."

Scott explains that being on-site every day is the best way to reach clients who fear and mistrust any forms of help. She says, "There are clients that we have to see every day. Some of the men are so isolated that they aren't speaking with anyone. They're in a corner by themselves, and they've been there for who knows how long. They appear to have no social supports whatsoever. You can't just walk up to them and say, 'Hey, come on with me, I'm going to help you.' You have to establish a relationship and you have to establish a trust."

Because of the work of the Shared Care team, Seaton House sees fewer disruptive clients, resulting in improved conditions for other clients and staff at the shelter.

Kavanagh says that the presence of the Shared Care team "relieves a lot of pressure; it makes the environment more friendly; it takes the gentlemen out of danger who require psychiatric medication. We have a wide variety of men staying here and a lot of them don't have much of a tolerance for somebody beside them making noise. They don't like to be irritated by somebody with a mental illness. They don't understand, they have their own issues, with addictions, with alcohol, a whole number of issues, so the tension is high, and this has made a difference." ■

"You can't just walk up to them and say, 'Hey, come on with me, I'm going to help you.' You have to establish a relationship and you have to establish a trust."

— Nancy Scott, shared mental health care nurse

services is a first step toward getting homeless people reintegrated into the health care system. She says "homeless people are reluctant to go to traditional clinics and hospitals. They're afraid they'll get turned away, afraid that they'll be stigmatized, or they simply do not have the money for transportation. If faced with the choice of having lunch or going to the doctor, most people would pick lunch.

"So it was presented to us time and again, that if services could be delivered on-site, not as a final solution, but instead to help people get stabilized, particularly for people with mental health disorders, that we could then get them either connected or reconnected with a doctor in the community, for more permanent use of medical care."

After the program began, it became evident that reconnecting with medical services was

PEOPLE WHO ARE HOMELESS AND mentally ill, often with no identification, mailing address or supports, face obstacles that can prevent them from getting the health care they need.

The Shared Care Clinical Outreach Program targets the needs of this isolated and vulnerable population. The program, now operating out of eight host sites in Toronto, started with an office in Seaton House last autumn.

A partnership between the Centre for Addiction and Mental Health and the Toronto Hospital's Department of Psychiatry, the Shared Care program delivers physical and mental health care services directly to clients: in hostels, shelters and drop-in centres.

So far, the results have been impressive. Bill Kavanagh, a shift supervisor at Seaton House, has seen a cycle of mental illness in clients of the shelter, clients who are "lost in the system, just wandering around.... They come from the hospital, they're on their medication, they're no longer a danger to themselves or anyone else. They end up at Seaton House, they run out of medication; next thing you know, they're off their medication."

He estimates that, since the introduction of the Shared Care program last September, the number of clients who take their medications properly increased from 10 per cent to 70 or 80 per cent.

Task force proposes harm reduction kits for crack users

Pilot project aims to help reduce infection and disease transmission

BY ANGELA BIANCHI

A HARM-REDUCTION PROGRAM TO reduce the health risks for people who use crack could arrive in Toronto by this autumn.

With goals such as reducing the transmission of HIV/AIDS, and improving the overall health of people who use crack, The Toronto Harm Reduction Task Force is seeking funding from the City of Toronto to develop 10,000 safer crack kits to be distributed free of charge through various organizations.

There will be two types of kits, one targeted at people who smoke crack and the other at those who inject it.

The smoker's kit will include items to prevent cuts and burns to the lips and mouth, such as a reusable glass stem pipette and non-copper screens to prevent ash inhalation and mouth burns. It will also have alcohol swabs for cleaning the mouthpiece, an antibacterial mouthwash, lip balm to prevent dryness and sores and a rubber mouth piece to prevent the mouth from coming into direct contact with heat.

The injection kit will include items to help reduce infection and transmission of disease, including cotton pellets to filter impurities from the solution; powdered vitamin C for breaking down crack and instructions on how to do this properly. (Vitamin C is used to prepare the "rocks" of crack for injecting. Vinegar or lemon juice, which are typically used, can cause severe damage to veins.) Bottles of sterilized water to dissolve the vitamin C powder will also be provided. Various organizations that offer needle exchange programs will be selected to distribute the kits and supply the needles.

The kits will be small enough to fit in a pocket and will include safer crack-use pamphlets, condoms, lubrication, multivitamins, matchbooks and antibacterial wipes for the skin.

An education campaign will be an integral component of the project.

Julia Barnett, a Task Force member and an AIDS Community and Needle Exchange Worker with Toronto Public Health, says that the glass pipette in the smoker's kit needs to be

seen as a health care device rather than drug paraphernalia.

The Task Force considers the inclusion of a glass pipette important because it reduces potential of personal harm, much like the supply of needles through Needle Exchange Programs.

In American cities where they are in use, crack kits have been useful in harm reduction and, more importantly, have brought this difficult-to-reach population in closer contact with the health care system.

"For the past five years, harm reduction workers have seen a need to provide such a program to crack users," says Barnett. "We found an increase in the use of crack and a higher number of people injecting it instead of smoking it."

"What we see is cause for worry," she adds. "Most users practice unsafe methods, and this makes them more vulnerable to infections. By providing them with safer mouth devices and safer injection methods we should see a reduction in health problems related to crack use. Indirectly, these kits will bring us in closer contact with this population and contribute greatly to our outreach efforts."

People who use crack provided input for deciding what goes in the kits.

Currently, people are using glass and plastic bottles, or items such as copper plumbing joints, to smoke their crack. These methods are dangerous and increase the risk of burns and cuts, which then become routes for infection, says Stephen Mereith, a program consultant at the Centre for Addiction and Mental Health and a Task Force consultant.

"Our concern is that if you're a sex trade worker and performing oral sex, theoretically you're at risk of transmitting HIV or other diseases," he says.

Both Barnett and Meredith agree that crack use is harmful but they say this pilot project could be beneficial on two fronts: first it will provide people who use crack with the knowledge

and materials they need to protect their health and that of the people with whom they come in contact; and second, it will allow front-line workers a real way of helping people who are using crack.

"Developing trust is important," adds Meredith, "so when down the road, they do want to introduce change in their lives, then you're the person they will want to come to."

Organizations chosen as safer crack kit distribution sites will have to undergo an orientation and training session. ■



Photo: Mara Korkola

The ethical implications of genetic research

The future may be here sooner than you think

BY CINDY MCGLYNN

The map of the human genetic structure (as researched by the Human Genome Project) is progressing ahead of schedule and will be ready in 2003. Couple that with ongoing private research, and the result is that scientists are homing in on the ability to isolate individual gene patterns and understand diseases, disorders and medical conditions more clearly. This means that the genetics of complex psychiatric diseases such as schizophrenia and bipolar disorder may soon be understood.

The ability to predict the predisposition for such conditions — and possibly even to prevent them — may be a godsend. But it carries with it serious ethical questions about privacy, discrimination and individual freedoms.

Many psychiatric conditions are multifactorial. While genetic factors may contribute to schizophrenia, for example, the disorder is not caused by genes alone. Environmental triggers must be considered, and even a map of the human genetic structure will not answer all the questions.

"We have no solid answers right now," says Dr. James Kennedy, head of neurogenetics at the Centre for Addiction and Mental Health. "For psychiatry, a lot of this discussion is in preparation for the near future."

Also an associate professor of psychiatry at the University of Toronto, Dr. Kennedy has conducted research in DNA testing to study the characteristics of conditions such as schizophrenia, bipolar disorder and obsessive-compulsive disorder.

Among ethical concerns are the social implications of genetic testing, such as genetic testing by insurers and employers to screen for "undesirable" characteristics.

Trudo Lemmens, bio-ethicist at the Centre for Addiction and Mental Health, wrote a paper on the topic in the March 1997 issue of *Politics and the Life Sciences*. Lemmens wrote that in Canada, workplace genetic testing is rare or nonexistent. It is more common in the U.S., but is still not widespread. (A 1989 survey found that 20 of the 500 largest American companies were conducting genetic tests or had done so in the previous 19 years.)

Lemmens writes, "although genetic testing remains rare, it will likely become a major employment selection tool."

For people with mental disorders, the implications are obvious. In a recent forum sponsored by Toronto's Mood Disorder Clinic, Barry Brown, an associate professor in philosophy at the University of Toronto, discussed how confidentiality and privacy will be crucial to preventing increased stigmatization and discrimination against people with psychiatric disorders.

Brown says there may be a general mistrust of genetics research following the eugenics practiced by many countries decades ago.

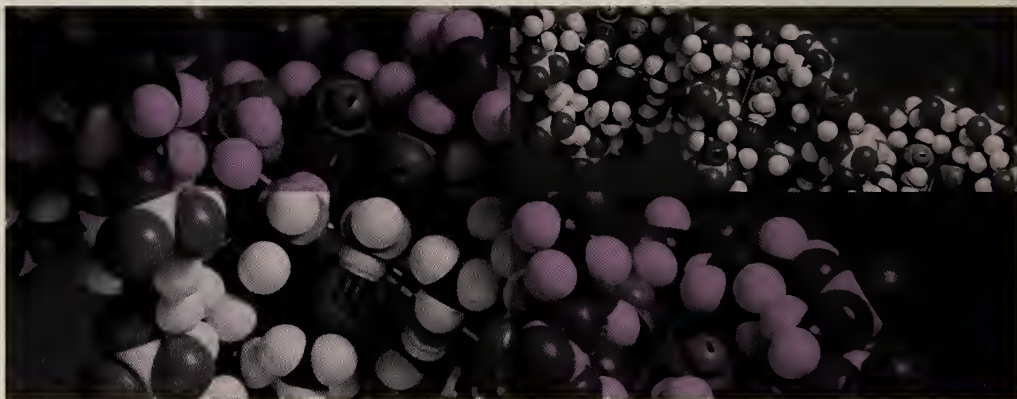
Lemmens says the focus of genetics research has changed.

"We're really not looking at trying to screen

Dr. Kennedy adds that screening out seemingly undesirable traits may bring unexpected consequences.

"Let's assume there's a gene for creativity or motivation or energy to compose music or to solve very complicated problems," Dr. Kennedy says. "Now, if those all come together in one person and there's too much, then they may create a disastrous outcome of mental disorganization or manic-depression or even schizophrenia. But if society would stop those people from reproducing, over time it would eliminate extremely useful genes that by themselves offer tremendous benefit."

How, then, to proceed? Lemmens writes that genetic testing in the workplace should be permitted only in exceptional circumstances, such as when a clear link has been established between a genetic abnormality and susceptibility



out undesirable genetic traits. We are trying to understand causes of disease. To understand why some people develop characteristics and why do some not.

"The problem is that, for many diseases, we currently do not have any cure," Lemmens explains. "Abortion then becomes the only option to avoid people being born with particular genetic diseases. This raises concerns. Abortion is already applied following genetic testing. The test for Down's Syndrome, for example, is a form of genetic testing. The question will be: 'Where do we draw the line between what is acceptable screening and what is not?' and 'When does pre-natal testing result in eugenic practices?'"

Lemmens also cautions that, although genetic information may indicate increased risk, researchers don't know yet whether all people with certain mutations will develop disorders or how the mutations interact with the environment.

to a workplace toxin. He says tests should be undertaken by third parties under the government's control and existing anti-discrimination laws — though perhaps insufficient — should help protect individuals.

The government itself, Brown says, is "way behind" when it comes to legislating genetic testing. The 1992 Privacy Commissioner's report makes recommendations, but Brown points out that they do not have the force of law.

"It may only be through a series of lawsuits and case law that a legislative framework is developed," he says.

"It's often a 'wait-and-see' approach," echoes Lemmens.

We may not be waiting long. While discussions of genetic treatments for psychiatric conditions such as schizophrenia are hypothetical now, says Dr. Kennedy, the human gene map will likely be ready in less than five years and "in 20 years, we'll have to grapple with these issues in reality."

Workshop offers discussion of seniors, substance abuse

BY TAMSEN TILLSON



All the bridge and shuffleboard in the world cannot alleviate the stark realities that people face as they age. It's a long list that includes chronic pain, boredom, loneliness, loss of social status and the death of loved ones. It is hardly surprising that many elderly people self-medicate.

The Etobicoke Coalition for the Prevention of Substance Misuse recently teamed up with the Toronto Area Addiction Services Coalition to organize a day-long workshop called "Investing in our Future: Older Persons and Substance Use," in Toronto.

About 130 attendees from addictions agencies, seniors' services and their funders came together to discuss this uniquely vulnerable sector of society and how best to help them. This is not the first workshop on addiction and the elderly, said Barbara Steep, co-chair of the conference and a community consultant at the Centre for Addiction and Mental Health, but it is the first systematic examination of the topic for agency workers with an eye to crossing over their services.

Organizers are hoping that better co-ordination of services will come out of the workshop, in addition to better enhancement of the skills on both sides. "If we're being really optimistic, we're hoping that the [health] minister is going to take notice," Steep says.

In her opening comments, Sue Hartman from the Ontario Substance

Abuse Bureau spoke of the urgency of the issue of addictions and the elderly, and how the problem is often misdiagnosed and underreported. She introduced specialized referral agencies, such as Community Older Persons Alcohol program in Toronto and Lifestyles Enrichment for Senior Adults in Ottawa, resources that workers can consult if they are looking for advice on how to deal with someone who they suspect has a problem.

Carl Asche, of a Bristol-Myers Squibb Pharmaceutical Group, discussed his groundbreaking research on the economic costs of falls in the elderly resulting from alcohol, substance abuse and overmedication.

A panel of three family members and a worker in a residential setting discussed the challenges of helping people over 55 with abuse issues, offered appropriate treatment and suggested ways to get the clients themselves on-side.

Julie Kiteley, one of three supervisors of Red Cross homemakers in attendance, found the workshop useful; she says, "It was an opportunity to find out what's out there in terms of resources for older persons who do have substance abuse problems. We can pass that along to families, and also to our outreach workers who see signs and symptoms of persons who may have these issues."

Few addictions services for seniors

One of the first questions someone is asked when they call to make a referral to the Community Older Persons Alcohol Program (COPA) is, "Which side of Bathurst Street do they live on?"

Bathurst Street, just west of downtown Toronto, is COPA's cutoff line. If elderly people with addiction problems live west of Bathurst, COPA can help them. If they live east of Bathurst, however, and need help, they're out of luck.

In Ontario, there are only two home-visit programs geared specifically to seniors with addiction problems, COPA and Ottawa's Lifestyle Enrichment for Senior Adults (LESA) program. According to primary care outreach worker Marilyn White-Campbell, the demand for such services exceeds the supply. "Seventy-two percent of the referrals that come to COPA are outside of the catchment area."

Most people don't know that this problem even exists. "It's an invisible population inasmuch as they're elderly, they may be poor, they may be women, they may be ethnic minorities," says White-Campbell. "They're not gen-Xers."

While agencies such as Matt Talbot's House (a long-term residence for older men with addiction problems) and Senior's Services (a substance use program at the Centre for Addiction and Mental Health), offer services to seniors, most are not equipped to offer home visits or outreach work.

Changes are slow in coming, primarily due to funding shortages. Of the \$110 million that Canada spends annually on addiction programs, only half of one per cent is dedicated to the treatment of seniors.

For a short time there was a project in London, Ont., similar to COPA and LESA, funded by St. Joseph's Hospital. The program, first entitled SMILE, and then Side Effects, ran out of funding in December 1997, despite its success.

"The small amount of data we were able to collect demonstrated that there was a cost savings," says Side Effects' manager, Irene Rusnell. "It was cheaper in health care dollars; in keeping people out of hospitals, reducing medications in many cases, preventing falls and fractures, and preventing premature institutionalization."

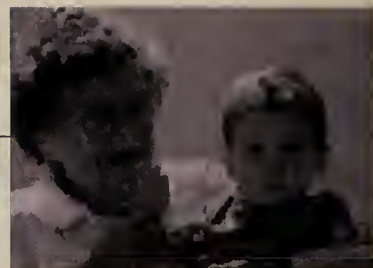
Thankfully, a scientific body of research is accumulating, and those who are crusading for addictions and the elderly are hoping that funding will follow.

Time grows short, however, and this problem will get worse before it gets better, says Barbara Steep, a community consultant at the Centre for Addiction and Mental Health. "The average number of people in this age group is growing more than any other," she says. "Our moms and dads will be affected soon. The time to plan is now."

TAMSEN TILLSON

Investing in our future

BY TAMSEN TILLSON



AS THE FIRST WAVE OF BABY BOOMERS APPROACHES retirement age, the proportion of people over 65 is going to balloon. A passing acquaintance with demographics will tell you that the number, which today stands at 12 per cent of the Canadian population, will over the next 40 years just about double, to 23 per cent.

Dr. Perry Kendall explains the importance of planning and preparing for this change. "Our society is highly dependent on chemicals. With an aging population, we need to devote increased attention to the misuse of drugs. We need a much greater awareness of the potential for iatrogenic harm, a much greater recognition of the problems of alcohol abuse and a continued focus on tobacco," he says.

"Fortunately we have some time to work on this, and 1999, the International Year of the Older Person, seems a good time to start."

As the current VP of Seniors' Health in Victoria, B.C. and former CEO of the Addiction Research Foundation, Kendall is one of a limited number whose working life has dealt both with seniors and addiction. Treating the problem in an ad hoc manner, as has been done in the past, is both inefficient and expensive, he says. Yet, until an integrated system is designed and put into place, it remains true that those who offer other types of services are the people who spot the majority of addiction problems in elderly people.

People over 55 with addictions to alcohol, prescribed or over-the-counter drugs, and/or tobacco fall into three categories. They are either newer users (those whose addictions have developed as a result of the losses associated with growing older), they are inadvertently

overmedicating or mixing substances in ways they shouldn't, or they are longtime, chronic users. It's easy to see how people over-medicate. Just 12 per cent of the population consumes between 1/4 and 1/3 of legally distributed drugs, and because our livers shrink and our metabolisms slow as we age, we are more, not less, sensitive to drugs and alcohol with time.

Addictions in seniors are particularly difficult to spot and to diagnose. Nanci Harris, program director at the Jean Tweed Treatment Centre, says that this is because the physical, social, and emotional problems associated with addiction are similar to those of aging. Even getting older people to acknowledge and work on their addiction problems can be difficult. "The fact that they're drinking in old age makes it difficult for them to believe they can quit," says Harris.

"For someone who's a chronic alcoholic, at this stage of the game they're very frail. These are the folks that are 55 going on 90," says Marilyn White-Campbell, a primary care outreach worker for Toronto's Community Older Persons Alcohol program. "When people come into treatment, they set their own goals; housing, leisure — leisure is a big big part of treatment, we want to get people involved in things that they previously enjoyed." And they use harm reduction strategies promoting healthy use if the client is not willing to abstain.

"We have all the information that is needed to define the problem, design programs, train staff, raise awareness and develop the partnerships that will be needed to respond. If we don't, then the costs are calculable and foreseeable," Kendall says.

Irene Rusnell, the manager of a London-based research project called Side Effects, which ran out of funding at the end of 1997, suggests a number of pointers for those hoping to pull together new programs for seniors with substance use problems.

- * "Seniors don't like to admit they have a problem," she says. Either they insist that they're just following doctors' orders, or in the case of alcohol, they deny that they misuse it. Doctors should be informed and on-side when dealing with clients.
- * The language you use and the approach you take is critical to the response you get. The idea of addiction is stigmatized enough to stop older people from requesting treatment. Outreach, and a health-oriented approach is crucial. Side Effects used to be called SMILE: Substance Misuse in London's Elderly. "They didn't like the label," Rusnell says, and were relieved when they changed the name.
- * Collecting data from this population is very difficult. When presented with a questionnaire, some of them simply leave the program. "They wanted the service but they didn't want to fill out the forms," she says.

Dr. Perry Kendall, VP of Seniors' Health in Victoria, B.C., has a number of general strategies to use in cases where there is no specialized treatment for seniors:

- * medications — Educate physicians and patients about proper use of medications; get rid of old medications and issue warnings on over-the-counter medications. Encourage pharmacists to keep a drug profile.
- * alcohol — "Some of the most effective forms of treatment seem to be in the area of attending not to the alcohol use or abuse itself," says Kendall, "but to other conditions that the patients report are bothering them," such as loneliness, health issues, misdiagnoses. To the degree that elderly addiction groups like Toronto's Community Older Person's Alcohol Program (COPA) were able to address these issues, the problems with alcohol consumption diminished "by themselves."
- * tobacco — Many older people wrongly believe they can't stop smoking, and even if they did, the damage is too far gone to undo any of it. The fact is that if you stop smoking at any age, even if you're elderly, your health will improve, your risk for disease will diminish and you'll live longer. "Even if you're 75 to 85, there are advantages to quitting smoking," says Kendall.



Male menopause

Hormone replacement therapy may relieve depressive symptoms in aging men

BY SUE McCLUSKEY

Problems such as reduced muscle mass and endurance, lower libido and depression have often been brushed off as "male mid-life crisis." However, new methods of testing for low levels of testosterone give credence to the reality of male menopause (also called andropause), and early studies of testosterone replacement therapy show promising results in treating these symptoms.

Urologist Dr. Jack Barkin, of Toronto's Male Health Centre, has found that a recently developed blood test for bioavailable testosterone is the most accurate way to determine the levels of "functioning hormones" that are available in a man's body.

Because the decline of testosterone is gradual in most men (unlike women's estrogen production, which stops abruptly at menopause), the symptoms of andropause are often overlooked, or marked up as inevitable signs of aging.

"It's easy to say, 'Well any man over the age of 50 can get a little bit depressed.' He's weaker, he's not sleeping as well, his moods may be a little bit [off]; that's normal for an aging man," Dr. Barkin says.

"But then when you start to look at the true change in muscle strength which we can measure, the increased risk of osteoporosis in a man with low serum testosterone levels, which we can also measure, the increased risk of coronary artery disease and arteriosclerosis and change in their lipid balance... these things all seem to be related to testosterone levels as well."

Dr. Joel Raskin, head of the Depression Clinic at the Centre for Addiction and Mental Health, and his team are developing protocols to study the incidence of low testosterone levels in men over the age of 45 who are depressed, leading up to a potential study of the effects of replacement therapy.

He says, "there's some suggestion that if you have a low testosterone level, it may be worthwhile to give testosterone treatment first."

Currently, the test for bioavailable testosterone is not covered by OHIP. Dr. Raskin says, "certainly in depressed men over the age of 45 or so, it may be something that we should be testing for routinely."

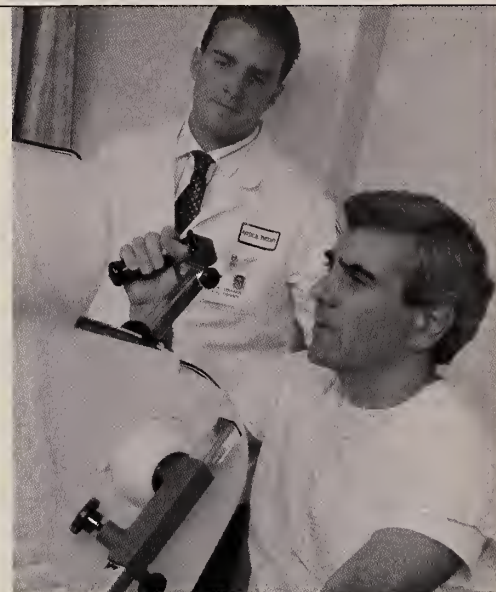
The overlap of symptoms between andropause and depression is a good indication that such attention is warranted. Dr. Raskin cites the St. Louis questionnaire for andropause, which questions the client's libido, energy, strength, endurance and enjoyment of life, among other issues.

Decreases in these categories, which indicate symptoms of andropause, are also traditional symptoms of depression. While not every symptom overlaps between the two, there is enough common ground that the connection between andropause and depression should be studied.

Dr. Barkin is enthusiastic about the use of testosterone in andropausal men. He suggests trying to replace the hormone as the first line of treatment, rather than giving an antidepressant, because the other effects on the system, in terms of bone mass, muscle strength and fat distribution "are so much more profound and beneficial."

Potential side-effects from testosterone replacement therapy include an increased risk of prostate cancer, but Dr. Barkin maintains that, as long as the levels of testosterone remain in the "normal" range, there are "virtually no side-effects."

Dr. Raskin cautions, however, that testosterone replacement will unlikely prove to be a panacea for depressive symptoms in all aging men. "Even if all those things improve, it doesn't necessarily mean that the person didn't have major depression. In a couple of the studies, not all of the depressed men who received testosterone therapy for depression felt better. And it's also possible that even with testosterone therapy, the person may still need an antidepressant."



Seniors undertreated for mental health

The highest rates for depression, dementia and suicide in Canada occur among the elderly, yet seniors are one of the most undertreated populations for mental health, according to a recent study in *Canadian Family Physician*. The study also found that younger patients are more likely than elderly patients to be referred to a psychiatrist or psychologist. However, rates of depression among the elderly range from 10 to 15 per cent in the community, and run as high as 50 per cent in nursing homes. The elderly account for 25 per cent of all suicides; in fact, elderly men have the highest suicide rate of any age group.

Depression, dementia and other mental health problems go undetected in more than one-third of the population aged 65 and over.

Dr. Jean Byers, clinical director of the geriatric psychiatry program at the Centre for Addiction and Mental Health, says that, according to some studies, the prevalence of dementia among nursing home residents is as high as 80 per cent.

Educating caregivers is crucial, she says, because "many people in nursing homes have dementia, and if they have dementia, then somewhere along the course, they may have behavioural problems. Also, in nursing homes there are people with depression, very often not adequately treated because it's not recognized."

Q & A

Common questions about seniors, mental health and addiction



How common is it for seniors to take their medication incorrectly?

Up to 30 per cent of elderly hospitalized patients are admitted because of medication toxicity. Elderly people are prone to drug-related problems, such as adverse drug reactions (ADR), for a variety of reasons, including inappropriate prescribing and noncompliance with prescribed medications. The key factor for ADR in the elderly is actually the high rate of drug use. It has been estimated that people over the age of 65 comprise 12 per cent of the population, but consume up to 30 per cent of the medications.

Approximately 90 per cent of ADRs in elderly patients presented to the emergency department may be attributed to five drug classes: narcotic non-steroidal anti-inflammatory drugs (NSAIDs), benzodiazepines, antacids and diuretics.

Physiologic changes associated with aging or disease, such as decreased vision, sense of touch and manual dexterity (which can affect ability to open medication containers), have been shown to be clinically significant risk factors in compliance with medication. The number of medications prescribed has also been shown to be a risk factor in compliance. Drugs should only be prescribed for an acceptable indication, at a correct dose and frequency, for an acceptable duration. Care must be taken to avoid inappropriate duplication of drugs and potentially adverse drug-disease and drug-drug interactions.

What does the latest research on aging and dementia show us?

Science loves simplicity, but the relationship between high blood pressure and cognitive decline turns out to be complicated, according to a new study.

Harvard researchers used data from ongoing large epidemiological study groups in the Boston area to assess the blood pressure and cognitive function of 3,657 people over the age of 65, who were followed for three to six years.

As the subjects' blood pressure increased, their cognitive function declined over time. But the relationship did not graph as a simple straight line.

The meandering nature of the relationship between increasing blood pressure and decreasing cognitive performance came as a surprise to the

researchers, who cannot explain it. But they conclude that the relationship between blood pressure and mental acuity is more complicated than previously believed.

What is the relationship between mental illness and addiction in the elderly?

Though there are no estimates of the prevalence of concurrent disorders in the elderly, professionals working with this population know that the combination of mental illness and alcohol or other drug dependence is a major challenge. Depression is particularly common, though it is often unclear whether the depression preceded or was the result of substance use. Also the extent of the depression may be unclear until the person is fully detoxified.

Evidence shows that a person with a drinking problem is at higher risk of having a mental health problem such as depression and anxiety. For instance, a person with anxiety problems will use alcohol to alleviate the symptoms.

Evidence also shows that drug users have a higher risk of concurrent mental health problems than alcoholics, but people with alcohol problems have a 2.3 times greater chance of having a psychiatric disorder.

Too often, says Wayne Skinner, director of the Concurrent Disorders Program at the Centre for Addiction and Mental Health, seniors who have concurrent disorders have tended to be underdiagnosed because "society often views any strange behaviour from this population as an element of the aging process."

How stressful is caring for seniors with mental health or addiction problems?

When they suspect that a senior has an alcohol addiction, many adult children who act as caregivers fall into two major categories, says Margaret Flower, manager for Seniors Services at the Centre for Addiction and Mental Health. Some adult children look at alcohol as the only pleasure their aging parent has left in life, while others demand that their parent seek treatment. Most worry about the senior's ability to manage day to day care, the possibility of drinking and driving, the possibility of mixing medication with alcohol, and the confusion and disorientation brought on by excessive drinking.

Symptoms of excessive drinking in seniors often go unnoticed, adds Flower, because they tend to mimic symptoms of aging, such as depression, memory loss and gastritis. As a result, the drinking is difficult to identify and this may result in the problem not being attended to.

Information on substance abuse and the elderly can be found in a 1998 Centre publication, *Choosing to Change*, which provides case studies on how health care workers can deal more effectively with senior clients.

What is the extent of substance use among seniors?

Older adults are less likely than people in other age groups to drink, but more likely to use psychoactive medication, particularly central nervous system depressant medications such as tranquilizers and sleeping pills. Just over half of Canadians aged 65 years and older are current drinkers (46 per cent of women and 66 per cent of men). Of the proportion of older adults who are frequent drinkers, 22 per cent drink four or more times a week. Older Canadians also consume less per drinking occasion (1.7 drinks versus 2.8 drinks) than other age groups. Only four per cent of older adults report problems associated with alcohol use.

In contrast to use of alcohol, use of prescribed and over-the-counter central nervous system depressant (CNS) medication generally increases with age. Some Canadian studies found that one in five, and in some areas one in two, older adults use a CNS drug, usually a sleeping pill or a tranquilizer. Data show that, over a number of years, two or three drinks a day for women and three to four drinks a day for men may result in serious health consequences, including liver or neurological damage.

Studies have shown that those using depressant medication were also more likely to be using alcohol to relax, to relieve anxiety/tensions, to forget worries and to relieve pain.

Sources: Centre for Addiction and Mental Health: *Concurrent Disorders Program and A Practical Guide For Counsellors: Alcohol and Drug Problems*, Institute for Clinical and Evaluative Studies, Toronto, J. American Medical Association, April 28, 1999, Health and Welfare Canada.

Fair and balanced information on cannabis

As European and North American counter-cultures embraced cannabis in the 1960s, health officials developed serious health concerns about the drug's effects on its users, leading to a frantic flurry of research activity.

Unfortunately, there was little quality control over the studies, and results were often inconclusive and controversial. By the end of the 1980s, fear about cannabis had faded from the public consciousness behind the glamour and threat of cocaine and its designer cousins. Now seen as a public health problem of lower priority, funding for new research studies became scarce, and many critical questions were left unanswered.

But the drug never did disappear. Rates of use, after peaking in the late 1970s, and showing a steady decline throughout the 1980s, have

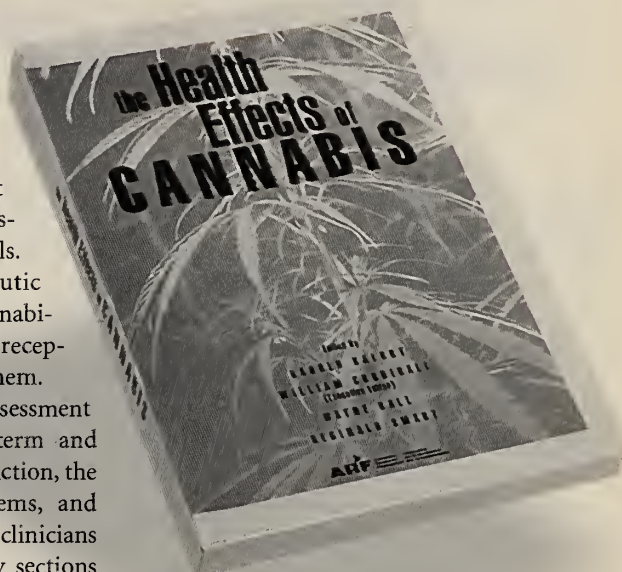
somewhat technical chapter, by Billy Martin and Edward Cone. Their observations begin to explain how the plant's active substances affect behaviour, and possibly affect hormonal balance and the immune system, documented in studies on animals.

If there are important therapeutic breakthroughs to be made with cannabinoids or synthetic analogs, this type of receptor-based research will help uncover them.

Other chapters include a detailed assessment of evidence relating to both short-term and chronic effects of the drug on brain function, the respiratory and cardiovascular systems, and reproduction. Of particular interest to clinicians treating young cannabis users are key sections describing the drug's actions on learning and memory, school performance, driving safety, and vulnerability to psychiatric disease.

It is evident that the scientific debate surrounding the public health consequences of cannabis has matured. In the final chapter, Wayne Hall, Robin Room, and Susan Bondy attempt to compare the acute and chronic health risks of cannabis with those of alcohol, tobacco and other drugs. They conclude that although cannabis users do report harm from their smoking, the public health significance of this behaviour (at least at current rates of use in North America) is less than that of tobacco or alcohol, since the prevalence of exposure to the latter substances is much higher. The largely qualitative analysis is limited by the lack of consistent epidemiological data on cannabis, but the scientific argument is rational. It is only by applying a consistent set of criteria across the pharmacological spectrum that the potential toxicity and public health implications of psychoactive agents, including cannabis, can be reasonably assessed.

The authors' conclusions will not satisfy anyone looking to support a polarized position on the public policy debates that continue unabated. However, *The Health Effects of Cannabis* does provide a wealth of fair and balanced information that will be helpful to both health care professionals and policy analysts who are faced with the continuing problems presented by this drug in our society.



It is evident that the scientific debate surrounding the public health consequences of cannabis has matured.

since rebounded in the United States, Canada and other countries. In response, a new review of cannabis and its consequences on health was commissioned by the World Health Organization (WHO), the summary report of which was published in 1997.

The *Health Effects of Cannabis* is a collection of the original reviews by many well-known international experts, reviews that comprised the background documentation of the WHO report. Updated this year, they stand as a significant and interesting body of work on their own.

While few of the health-related questions raised in these papers are new, it is clear that the field has evolved significantly, both scientifically and philosophically, since Harold Kalant edited the previous WHO-Addiction Research Foundation summary report and background papers in 1981.

The increased competition for research funds in recent years has resulted in better quality research and in more consistent data. For example, the discovery of cannabinoid receptors is described in a fascinating, albeit

KEVIN O'BRIEN FEHR, Ph.D., is director of External Scientific Affairs for Glaxo Wellcome Inc. and was co-editor of *Cannabis and Health Hazards* (ARF Books, 1993) with Harold Kalant.

The Health Effects of Cannabis, eds. H. Kalant, W. Corrigall, W. Hall and R. Smart, Centre for Addiction and Mental Health, Toronto, Ont., 1999, 526 pp., \$89.95.

To order copies of *The Health Effects of Cannabis*, contact:
Marketing and Sales Services
Centre for Addiction and Mental Health
33 Russell Street
Toronto, ON Canada
M5S 2S1
Tel.: 1-800-661-1111 or (416) 595-6059 in Toronto
e-mail: mktg@arf.org

Also Noted...

Fire & Reason

Fire & Reason, a collection of written and visual work by and for youth who have struggled with depression or bipolar disorder, has just launched its first 'zine.

For more information, contact *Fire & Reason* at: <fire_reason@yahoo.com> or (416) 760-2129.

The Last Word

Breaking the cycle of substance abuse: altering children's fate



MIRELLA DE CIVITA



RODRIGUE PARÉ

We welcome submissions from our readers for opinion pieces. For information, contact: The Editor
Journal of Addiction and Mental Health
33 Russell St., Toronto, Ontario M5S 2S1
tel.: (416) 595-6714
e-mail: <adubey@arf.org>

WHEN ONE THINKS OF THE FAMILY, AN IMAGE THAT comes to mind is that of a mobile. The interrelation between the different parts of a mobile, like the different members of a family, makes it difficult to move one part without affecting the others. When a parent is affected by addiction, the problem touches all members of the family.

For many parents who are substance abusers, a family history of intergenerational addiction influences their lives as well as the lives of their children. From this perspective, it is difficult to ignore the fate of children living with parents addicted to alcohol or drugs.

In preliminary analyses for a recent study, we found that 78 per cent of 4,819 clients who sought treatment for substance abuse in the last seven years reported having a family member (e.g., parents, grandparents, aunts/uncles and siblings) with an alcohol problem. We then set out to identify how many of these clients were themselves parents. Data were collected on 2165 clients who sought treatment in the last three years. Among clients identified as parents, 70 per cent reported having children aged 19 and younger. Among the children identified, 57 per cent were aged nine and younger.

Exploring the family situation for children with a parent in treatment revealed that a substantial number of children had experienced some form of family breakdown. We also identified a subgroup of children whose circumstances placed them at a social disadvantage — parental unemployment, low parental education, and low family income. Taking a retrospective approach indicated a disturbing intergenerational relation between parents' substance abuse and family history of alcohol problems.

From a sample of 1141 children, 23 per cent were facing cross-generational sources of risk for substance abuse. In truth, however, all of the children identified are at considerable risk for future substance abuse and other psychosocial problems.

Research has shown that family disruption, parental deviance, inconsistent parenting, and low family cohesiveness tended to characterize the childhood period of problem drinkers and illicit drug users (Selnow, 1987).

But there is more to this rather bleak portrait of children facing multiple sources of familial risk of substance use. There is, after all, the compensating force of opportunity.

Moving from discourse to action, treatment providers can work together as advocates for equal access to resources, services and opportunities to promote children's well-being. Rather than paying lip service to the importance of addressing children's needs, professionals should seek to form partnerships with policy makers and community leaders in negotiating the contents, procedures, and processes of intervention to promote the development of healthy children and families.

Certainly, it is not easy to secure funds at the federal or provincial level. Yet we must not underestimate our individual efforts to promote

human welfare at every given opportunity. Members of boards of directors in different treatment centres can begin the process of change by allocating a portion of their funds to promote children's well-being. Taking small steps will, in time, create big changes in the lives of children and their families.

Opportunities denied in childhood mean lost chances in adulthood. Our data shed light on an easily accessible, yet often ignored, vulnerable population. Parents who seek treatment represent a subgroup of substance abusers who are relatively easy to target. Providing care and treatment for children must be an integral part of the parent's treatment. Any attempt to intervene in the lives of children must begin as soon as the parent enters treatment and involve cross-system collaboration and equal co-operation. We cannot expect children or the rest of the family to adapt instantly to the new and improved parent.

Such treatment for children raises a number of ethical questions. When and how do we propose care for children? What kinds of strategies would more effectively motivate parents to consent to the children's participation? How should programs be tailored to respond to changing developmental needs? How can we help parents and children make the transition to their daily lives following treatment? What should be the duration of such programs?

Professional groups are bound to disagree on how best to intervene in the lives of children living with substance-abusing parents. At present, there is no state-of-the-art preventive intervention program for children at risk for substance abuse and other forms of psychosocial maladjustment. Each ethos of prevention, be it proactive or reactive, collective or empowering, will have its own champions who will defend their practice as being the most effective approach to break the cycle of substance addiction.

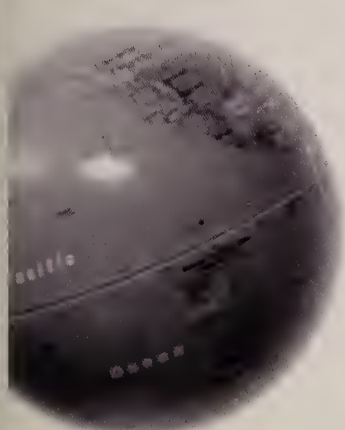
The ideal preventive approach should involve a comprehensive system of care that includes an array of services developed to promote children's well-being across different stages of their lives. There is no guarantee that early intervention will inoculate children against future challenges. Initial positive changes may diminish when there are no environmental supports to maintain progress.

If we are to break the cycle of substance abuse and help children alter their fate, we must begin by shifting our focus from one of blame and cause to one of building family strengths and developing partnerships with parents in caring for their children. ■

REFERENCES Selnow, G. (1987). Parent-child relationships and single and two parent families: Implications for substance abuse. *Journal of Drug Education*, 17, 315-326.

Rodrigue Paré is the director of Maison Jean Lapointe, a non-profit treatment centre for adults with substance abuse problems. Mirella De Civita is a Ph.D. candidate in Psychology Research at the University of Montreal. She is currently conducting research at Maison Jean Lapointe.

Conferences



CANADA

Summer Institute (addiction and mental health courses)

May 31-June 11, Toronto, Ontario.
Contact: Education and Training,
Centre for Addiction and
Mental Health, 33 Russell St.,
Toronto, ON M5S 2S1,
tel (416) 595-6020,
fax (416) 595-6644.

Inhalants and Non-Beverage Alcohol Conference

June 6-8, Winnipeg, Manitoba.
Contact: Estelle Sures, Conference
Co-ordinator, 187 St. Mary's Road,
Winnipeg, MB R2H 1J2,
tel (204) 233-1411,
fax (204) 237-3408,
web <www.mts.net/~infotext>.

National Healthcare Leadership Conference – Revitalizing Our Services Revitalizing Our Selves

June 6-9, Quebec City, Quebec.
Contact: National Healthcare
Leadership Conference Secretariat,
tel (613) 241-8005 ext. 211,
fax (613) 241-5055, e-mail
<chaconf@canadian-healthcare.org>.

Canadian Public Health Association 90th Annual Conference

June 6-9, Winnipeg, Manitoba.
Contact: CPHA Conferences,
400-1565 Carling Ave.,
Ottawa, ON K1Z 8R1,

tel (613) 725-3769,
fax (613) 725-9826,
e-mail <conferences@cpha.ca>,
web <www.cpha.ca>.

15th Annual Conference of the Crisis Workers Society of Ontario

June 9-11, Toronto, Ontario.
Contact: Joanne Walsh, Saint Elizabeth
Health Care, 2 Lansing Sq. Ste 600,
North York, ON M2J 4P8,
tel (416) 747-3400 ext. 2056,
fax (416) 498-0213,
e-mail <bussdev@saintelizabeth.com>.

Mental Health Services: Restructuring and Public Safety

June 9-11, Midland, Ontario.
Contact: Susan LaBrie,
tel (705) 549-3181 ext. 2680,
web <www.mhcv.on.ca/forensic.htm>.

Canadian Mental Health Association – Ontario Division 1999 Conference

June 10-11, Timmins, Ontario.
Contact: CMHA Ontario Division,
180 Dundas St. W., Suite 2301,
Toronto, ON M5G 1Z8,
tel (416) 977-5580 or 1-800-875-6213,
web <www.ontario.cmha.ca>.

13th Annual Conference – Ontario Federation of Community Mental Health and Addiction Programs

June 16-18, Kingston, Ontario.
Contact: Janet Chui, 250 Consumers
Rd., Suite 806, Toronto, ON M2J 4V6,
tel (416) 490-8900 ext. 21,
fax (416) 490-8902,
web <www.ofcmhap.on.ca>.

9th Canadian Social Policy Conference

June 20-23, Montréal Quebec.
Contact: Celine Beauchemin, École de
service sociale, Université de Montréal,
CP6128, Succ. Centre-ville,
Montréal, PQ H3C 3J7,
tel (514) 343-6596,
fax (514) 343-2493.

Crisis Prevention Institute, Training Dates

July 6-9, Toronto, Ontario and Calgary,

Alberta. Contact: Carol Hanrahan,
Crisis Prevention Institute, Inc.,
3315-K North 124th Street,
Brookfield, WI 53005,
tel 1-800-558-8976,
fax (414) 783-5906,
e-mail <info@crisisprevention.com>,
web <www.crisisprevention.com>.

40th Annual Institute on Addiction Studies, "Celebrating the Journey"

July 11-15, Kempenfelt Conference
Centre, Barrie, Ontario.

Contact: Nancy Bradshaw or
Sandra Caswell, Concerns Canada,
tel (416) 293-3400,
e-mail <concerns@sympatico.ca>.

AIDS Impact 1999 – Biopsychosocial Aspects of HIV Infection

July 15-18, Ottawa, Ontario. Contact:
Canadian Psychological Association,
205-151 Slater Street,
Ottawa ON K1P 5H3,
tel (613) 237-2144,
fax (613) 237-1674,
web <www.aidsimpact.com>.

8th Annual David Berman Memorial Dual Disorder Conference

October 14-15, Vancouver, British
Columbia. Contact: Dual Diagnosis
Program, Attention: Laurel Lafant,
1-520 Powell Street,
Vancouver, BC V6A 1G9,
tel (604) 255-9843,
fax (604) 251-4579.

International Association of Psychosocial Rehabilitation Services, Ontario Chapter, 5th Bi-Annual Conference

October 20-22, Niagara Falls, Ontario.
Contact: Sheila Bistro,
tel (905) 641-5222.

National Association of Dual Diagnosis Conference (developmental disability and mental health needs)

November 10-13, Niagara Falls,
Ontario. Contact: Susan Morris,
tel (914) 331-4336,

e-mail <nadd@ulster.net>,
web <www.thenadd.org>.

Beyond 2000: Healthy Tomorrows for Children and Youth

June 14-18, 2000, Ottawa, Ontario.
Contact: Kim Tytler, Director, Marketing
and Communications, Canadian
Institute of Child Health,
512-885 Meadowlands Drive,
Ottawa, ON K2C 3N2,
fax (613) 224-4145,
e-mail <cich@igs.net>.

7th Congress World Association for Infant Mental Health

July 26-30, 2000, Montréal, Quebec.
Contact: WAIMH Secretariat,
550 Sherbrooke Street West,
West Tower, Suite 490,
Montréal, QC H3A 1B9,
tel (514) 398-3770,
fax (514) 398-4854,
e-mail <waimh@ums1.lan.mcgill.ca>,
web <www.mcgill.ca/mco/waimh>.



UNITED STATES

1999 Summer Institute for Alcohol and Other Drug Studies and Advanced Social Work Practice

July 7-23, Buffalo, New York. Contact: Rosemarie Goi, Director, Institute for Addictions Studies and Training, School of Social Work, State University of New York at Buffalo, 359 Baldy Hall, Box 601050, Buffalo NY 14260-1050, tel (716) 645-6140, fax (716) 645-3883.

National Alliance to End Homelessness Annual Conference

July 14-17, Washington, DC. Contact: National Alliance to End Homelessness, tel (202) 638-1526.

National Summit: The National Mental Health Consumers' Self-Help Clearinghouse

August 25-29, Portland, Oregon. Contact: 1211 Chestnut St., Suite 1000, Philadelphia, PA 19107, tel (800) 553-4539 or (215) 751-1810, TTY (215) 751-9655, fax (215) 636-6310, e-mail <info@mhselfhelp.org>, web <www.mhselfhelp.org>.

Substance Abuse Treatment Protocols for People with Disabilities "Reality & Resources"

September 16, Madison, Wisconsin. Contact: Bob Oslo, 2411 Park Rd., Mosinee WI 54455-8490, tel (800) 359-5826, fax (715) 241-7182, e-mail <wadda@juno.com>.

1999 Great Lakes Conference on Addictions and Mental Health

September 26-29, Indianapolis, Indiana. Contact: Dennis Miller, P.O. Box 30380, Indianapolis, IN 46230-0380, tel (317) 283-8315, fax (317) 283-1038, e-mail <gr8lakestr@aol.com>.

Canadian Academy of Child Psychiatry/American Academy of Child and Adolescent Psychiatry

October 19-24, Chicago, Illinois. Contact: AACAP, Meetings Dept., 3615 Wisconsin Avenue NW, Washington, DC 20016-3007.

National Education Association for Homeless Children and Youth Conference

November 6-9, Orlando, Florida. Contact: National Education Association for Homeless Children and Youth, tel (805) 599-8483.

ABROAD

College on Problems of Drug Dependence (Sixty-first Annual Scientific Meeting)

June 12-17, Acapulco, Mexico. Contact: Dr. Martin W. Adler, Executive Officer, CPDD, Dept. of Pharmacology, Temple University School of Medicine, 3420 N. Broad St., Philadelphia, PA 19140, fax (215) 707-1904.

2nd World Congress for Psychotherapy

July 4-8, Vienna, Austria. Contact: World Council for Psychotherapy, tel 0043 1 512 0444, fax 0043 1 513 1729, e-mail <wcp.office@pop.magnet.at>.

Towards the Year 2000 - A Middle East Summer Institute on Drug Use Project

July 17-23, 1999, Jerusalem, Israel. Contact: S. Einstein, Ph.D., 113/41 Olei Hagardom East Talpiot, Jerusalem, Israel, tel 972-2-6733130, fax 972-2-6732753, e-mail <einstein@netvision.net.il>.

11th World Congress of Psychiatry

Aug 6-11, Hamburg, Germany. Contact: XI World Congress of Psychiatry, CPO Hanser Service, Hanser & Co. GmbH, Office Hamburg, PO Box 1221, D-22882 Barsbüttel, Germany, tel 49 40 670 8820, fax 49 40 670 3283, e-mail <cpo@wpa-hamburg.de>.

XIII Brazilian Congress on Alcoholism and Other Dependencies

August 11-15, Rio de Janeiro, Brazil. Contact: Claudia Antonaccio, tel 55 21 553 6628, fax 55 21 551 4012, e-mail <jcdias@spacenet.com.br>, web <www.abcadrio99.com.br>.

38th International Congress on Alcohol and Drug Dependence

August 16-20, Vienna, Austria. Contact: Fiona Fretz-Tongue, Project Co-ordinator, International Council on Alcohol and Addictions, Case Postale 189, 1001 Lausanne, Switzerland, tel 41 21 320 98 65, fax 41 21 320 98 17, e-mail <icaa@pingnet.ch>, web <www.icaa.ch>.

European Symposium on Community Action to Prevent Alcohol Problems - European Network on Local Alcohol Prevention, Research and Evaluation

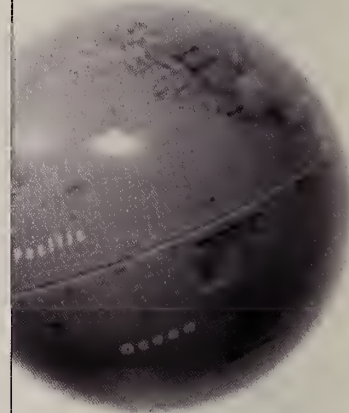
November 18-20, Porto Portugal.

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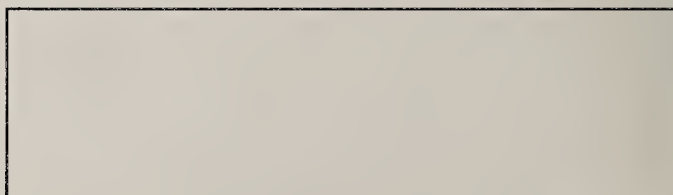
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July/August
1999
Volume 2
Number 4

Diversity:
ethnocultural
issues
in understanding,
prevention
and care

barriers^{to}
mental health
treatment

substance
abuse
services^{and}
cultural
communities

JUDICIALS READING ROOM
Humanities & Social Sciences

DYSTHYMIA

Disorder of
discontent

PILL ART

Colleen
Wolstenholme's
sculpture

CHILD POVERTY

Study looks
at multiple
risk factors



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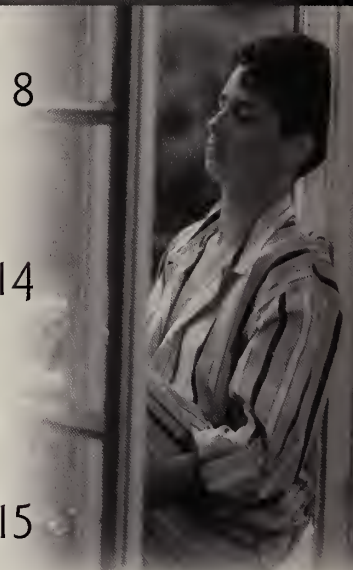
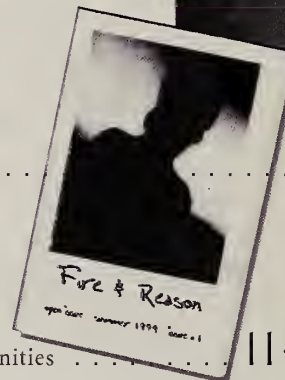
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Cover

Tova McMillan
A Woman in the Tree
etching, 10" x 8"

From Foresight/Foursite: A CAMH Art Exhibit, 1999

Tova McMillan has been an artist and poet for 30 years.

"Women are strong, though we don't always know our inner strength,"
says McMillan. "We're learning to regain or recognize it. Strength is innate
in all human beings, but because of shame and guilt, it can be weakened.

"This is what the image is about."

News from the Centre

"This partnership integrates client preferences, expressed needs, cultural beliefs and practices."

From the *Philosophy of Care, Future Directions: Final Report of the Strategic Planning Process*, Centre for Addiction and Mental Health, 1999

Improving access to all of our services is a key priority here at the Centre, a priority that includes awareness of diversity issues. The most visible evidence of this commitment is in the clinical programs that we offer (and continue to develop), that incorporate such awareness into their delivery of service.

Less obvious, but equally important, is the behind-the-scenes work, done to ensure that our entire organizational philosophy reflects our commitment to diversity issues.

Because the focus of this issue of *The Journal of Addiction and Mental Health* is on ethnocultural diversity, it is an opportune time to reflect on some of the Centre's own initiatives in this area.

The Centre offers a wide range of culturally sensitive clinical programs, including, for example, SAPACCY, the Substance Abuse Program for African-Canadian and Caribbean Youth. This program, which works with youth, families and community partners, is geared toward substance abuse prevention and early intervention, and highlights the role of culture, history, society and behaviour in generating and sustaining substance abuse.

Our Structured Relapse Prevention and Guided Self Change programs have been adapted for the Chinese community, and include community development and public education components. Problem Gambling Services are offered in Portuguese and French, and the Addiction Medicine Clinic offers services to Cantonese clients. In other areas, the Centre provides a cultural interpreter program and an aboriginal addiction service is in development.

The Ethnoracial Services Committee in General Psychiatry has established a framework to guide its work around ethnoracial psychiatric issues as they relate specifically to organizational policies and structures, human resources, education and training and communications.

Similarly, the Centre's programs for women are guided by cultural sensitivity.

Most recently, the Centre provided the expertise of our health professionals to support the complex mental health needs of Kosovar refugees arriving in Canada.

To help build expertise in the broader community, the Centre offers cross-cultural counselling, is working with community partners to examine accessibility to addiction services for people in the Tamil, Punjabi and Polish communities, and is examining ethnocultural needs in addiction prevention and treatment for seniors. This includes the possibility of developing "train-the-trainer" packages for counsellors and multilingual public information materials for seniors.

To build cultural competence among our own staff, our Cultural Consultation Service works with clinical programs to ensure that services are culturally appropriate. The Distinguished Clinician Program provides training and consultation on issues related to race, refugees and cultural factors affecting care, while the Meet our Community Partners program aims to increase our staff's sensitivity and awareness by bringing in ethnocultural groups to speak about their first-hand experiences in Canada's health system.

Entrenched within many of the principles that guide the Centre's work is our commitment to welcoming and fostering sensitivity to, and respect for, diversity. Our governance policy states that the board membership must have regard for demographic, cultural, gender, linguistic, religious, economic, geographic, ethnic and social characteristics of the communities served. Our Core Values reflect the Centre's commitment to providing services that "are sensitive to race, culture and ethnicity" and providing an "environment that welcomes diversity and supports learning, scholarship, self-scrutiny and open, respectful debate." Our Statement of Culture commits that the Centre's workplace will be characterized by "respect for diversity of culture, race, gender, age, abilities, religions and sexual orientation, which is demonstrated by inclusive practices and policies."

Our Diversity Committee co-ordinates the Centre's efforts in all these areas. The mandate of this committee is to address the issue of diversity from a cultural point of view, to build on diversity initiatives already in place at the Centre, and to give advice to senior management, to ensure that any organizational change includes a diversity focus in its approach.

Other News: For readers interested in learning more about the Centre's future plans, the Centre's *Final Report of the Strategic Planning Process* and the *1999/2000 Operating Plan* are available from Public Affairs at (416) 595 6878.

BY RENA SCHEFFER

Letters



In your May/June 1999 issue of *The Journal*, the article called "Few addictions services for seniors" states that, "In Ontario, there are only two home visit programs geared specifically to seniors with addiction programs, the COPA and LESA programs."

I would like to inform you that the Elliot Lake Family Life Centre in East Algoma, Ontario, has had a Seniors Outreach Program (funded by the Ontario Substance Abuse Bureau) in operation for approximately six years.

Thank you in advance for making your readers aware of this fact. For further information concerning our program, you may contact us at:

The Elliot Lake Family Life Centre
9 Oakland Blvd., Suite 2
Elliot Lake, Ontario
P5A 2T1
Tel: (705) 848-2585
Fax: (705) 848-9687

Letters to the editor are welcome. They must be signed and include a daytime telephone number. Letters may be edited to fit space.

Send letters to:
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Drugs in the Media

"Twenty-six per cent of movies portrayed illicit drug use in a humorous context."

This is one of many findings from *Substance Use in Popular Movies and Music*, a study conducted by Mediascope, a non-profit organization concerned with accurate and responsible portrayal of social and health issues in the media. View the full report at: www.health.org/mediastudy/index.htm.

SHEILA LACROIX

In Brief



Cigarettes, Kosovars and the Red Cross

Red Cross staff, working with heavy-smoking Kosovar refugees at CFB Borden, were caught between their mandate to ensure the comfort and respect the cultural traditions of people in their care, and an internal regulation that bars them from buying or procuring cigarettes for anyone. Creative problem-solving settled the issue: private donors can now leave cartons of cigarettes with the camp's security guards, a representative from the refugee committee within the camp is notified of their arrival and then one of the refugees gathers them up for distribution. The Kosovars are allowed to light up in their living quarters and the mess hall.

Television and eating disorders

Since the widespread introduction of television to Fiji in 1995, there has been a five-fold increase in the symptoms of eating disorders among teenage girls in that Pacific island nation. Harvard researcher Anne Becker recently revealed her findings on this subject in a speech delivered to a meeting of the American Psychiatric Association. Though she was quick to point out that the study does not definitely establish a causal relationship between television and eating disorders, Becker said that the increase was significant, particularly because Fiji culture traditionally stresses the importance of eating well and having a robust figure.

Sniffing out drugs in Alberta schools

A recent collaboration between the RCMP and the public and Catholic school boards in St. Albert, a small city north of Edmonton, Alberta, will result in trained police dogs prowling the halls of four schools sniffing for drugs. If illicit substances are discovered in a locker, the student found responsible will be expelled from school, but will be offered counselling and the chance to finish school through long-distance learning.

Harm reduction recommended for homeless addicts

According to the Toronto-based report *From the Revolving Door to the Open Door*, prepared by a task force composed of service providers and users of addiction programs, homeless drug addicts and alcoholics are not being served by conventional addiction programs. The chief recommendation, among the 21 in the report, was to adopt a harm reduction strategy for heroin addicts that includes the creation of more methadone programs, needle exchanges and safe-houses for injecting. Pam Joliffe, executive director of the Fred Victor Centre, says, "We want to make sure, first of all, that people aren't dying... Harm reduction really is a holistic and a step-by-step approach to helping a person... progress towards a life that feels more in control to them."

Cracking down on air rage

Spurred on by an international airline industry report showing a 400 per cent increase in the incidence of air rage since 1995, Transport Canada is seeking to become a leader in the fight against this form of flight interference. A poster and "ticket insert" campaign will feature cartoons of inappropriate behaviour, such as smoking and drinking while on board, with red bars cutting through the image. The intent of the initiative is to make clear the zero tolerance policy that now awaits any unruly passengers. Starting this summer, anyone found guilty of committing an act of air rage will have a criminal record and face fines of up to \$5,000 or imprisonment.

Swiss vote yes to heroin program

In a recent national referendum, the people of Switzerland have agreed to allow a contro-

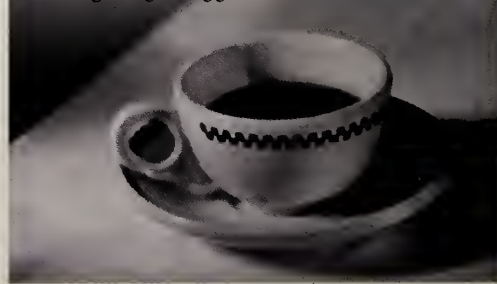
versial harm reduction program to continue — and expand. As one of several harm reduction strategies the Swiss have undertaken, the program allows doctors to prescribe heroin to a small group of addicts. Since it was implemented in 1993, the program has led to decreases in the number of new people testing HIV positive, crime rates, mortality rates, and prostitution and homelessness related to heroin addiction.

Countering the rising potency of street heroin

Researchers at Columbia University are supplying heroin addicts with pure heroin and paying them for their time in a U.S. federally funded study. Looking at ways in which existing medications might help defeat drug addiction, researchers give the subjects medications that neutralize the heroin's high, and then give regular doses of pure heroin. With the increase over the past few years in the quality of heroin sold on the streets, this study will allow researchers to learn if higher doses of drugs regularly prescribed to combat heroin addiction, such as methadone, are still effective.

Coffee reduces gallstone risk

Harvard researchers have found that consuming at least two cups of coffee a day will reduce men's risk of developing gallstones. Composed mainly of cholesterol and caused by fatty diets, gallstones afflict an estimated 2.5 million Canadians each year. In their report, published in the *Journal of the American Medical Association* on June 8, researchers say that the caffeine consumed by drinking two to three cups of regular coffee per day will prevent cholesterol from crystallizing, reduce absorption of the fluid preceding the formation of the stones, or increase the flow of bile through the bladder. They caution that these results should not be taken as a recommendation to increase consumption of coffee, however, as heavy coffee drinking might aggravate other health risks.



Telepsychiatry – video technology provides service in rural areas

WHEN PEOPLE IN CAMPBELLFORD, a small community in southeastern Ontario, need psychiatric assessments, they face a two-and-one-half-hour drive to Toronto.

Televideo conferencing technology is changing that.

Although televideo conferencing technology has been used in psychiatry since the 1960s, it has typically been used only for teaching, because in the past there were questions about its reliability and confidentiality.

A recent pilot study, a partnership of the Centre for Addiction and Mental Health in Toronto and the Campbellford Community Mental Health Centre, looked at the effectiveness of this technology for psychiatric assessments. This study was the first of its kind in Ontario, and follows studies done in other provinces, such as Nova Scotia and Alberta, where telepsychiatry has been used and evaluated for its success.

The study consisted of 40 psychiatric assessments and measured the patient and psychiatrist's response to a general psychiatric interview conducted by televideo over an actual geographic distance. Previous televideo studies were done in an artificial setting by connecting two rooms in the same building.

The small room set-up lends itself to a very intimate and one-on-one meeting between the patient and psychiatrist. "Psychiatry is ideally suited to this technology," explains Gene Duplessis, director of the Wellness Centre at the Campbellford Mental Health Centre. "Some patients prefer to see a psychiatrist in this setting because it is less intimidating and the patient has more control."

Results were measured through the Interview Satisfaction Scale, which showed that parents did not rate the televideo and face-to-face interviews significantly differently (1.87 and 1.59, respectively, on a scale of 1 to 5, where 1 = agree strongly and 5 = disagree strongly). Half of the sample group had a history of psychosis and the other half did not. In a recent Alberta study, 84 per cent of consumers surveyed said they were satisfied at the time of the consultation.

Campbellford serves a catchment area of 25,000 people, which, according to Ontario Ministry of Health benchmarks, should have the equivalent of 2.5 full-time psychiatrists to provide adequate psychiatric services to the area. Currently, Dr. John Farewell, a psychiatrist with the Assessment Clinic at the Centre for Addiction and Mental Health, provides on-site services to the community one half-day a month.

The cost of the technology was a barrier in the past, but today the technology can be purchased for approximately \$3,000. This provides a very accessible and cost-effective option for facilities such as the Campbellford Community Mental Health Centre.

The cost for the telephone lines is approximately \$1/minute, thus a one-hour assessment costs about \$60. This is minimal compared to the travel, lodging, meal and time costs of doctors travelling to rural areas to provide the same services.

Any expansion of the use of telepsychiatry faces one major obstacle: currently, OHIP does not cover assessments unless the patient and the psychiatrist are in the same room. To date, sessional fees have been used to fund this service.

Dr. Farewell says that, although telepsychiatry is currently only used for psychiatric assessment and some simple follow-up meetings, there is an opportunity for further use of the technology. Other psychiatric services, such as weekly meetings for ongoing care, emergency consultations and psychotherapy, could also be provided by televideo.

As a result of the pilot study, Campbellford Community Mental Health Centre now offers telepsychiatry as a regular service to its clients.

CHRISTA HAANSTRA

Ontario schools to include more drug and alcohol information

WHEN THEY GO BACK TO SCHOOL this September, Ontario students will find their curriculum expanded to include extensive education on drug and alcohol prevention.

Under the new health and physical education curriculum, released by the Ministry of Education and Training, students in Grades 9 and 10 are expected to learn about the major factors that contribute to alcohol and drug abuse. The new "healthy living" curriculum highlights the school and community resources involved in education, prevention and treatment with respect to alcohol, tobacco and other drugs, as well as the importance of physical activity for a healthy lifestyle.

Students in Grade 9 will not only be expected to know facts about the effects of the use

and abuse of alcohol, tobacco and other drugs, but will also be expected to be able to identify the school and community resources involved in drug and alcohol education, prevention and treatment.

Grade 10 students will learn about the factors that lead to addiction, as well as physiological and sociological effects and legal aspects of substance use and abuse.

"The previous curriculum dated back to the 1970s, but the school boards had more current programs in place," says Ilze Purmalis, policy analyst with the Curriculum Assessment Policy Branch. "All content in the new curriculum is not totally new, because it has always stressed physical activity and sex education. It is a continuum, with a revised focus on healthy living education."

The new curriculum is more specific, she says, in its learning objectives, and focuses on the range of skills necessary for a healthy lifestyle. "This is an inclusive curriculum," Purmalis adds. "It is a very heroic effort."

As part of the new curriculum, a program called ACTION: Alcohol and Tobacco Health Promotion Project for Youth was established by the Ontario Physical Health and Education Association. ACTION visits schools in 21 communities throughout the province to discuss substance abuse prevention.

The new learning requirements build on the health and physical education curriculum for Grades 1 to 8 released by the Ministry of Health in the fall of 1998. The curriculum for students in Grades 11 and 12 is expected to be released this September. DON BARRIE

Drug companies disapprove of artist's work

A VANCOUVER-BASED ARTIST'S exploration of the politics of psychoactive medication has gained her recognition in the Canadian art world, and trouble from major international drug companies.

As part of her work, Colleen Wolstenholme casts exact silver reproductions of a range of pills, fashioning them into jewelry. Medications as diverse as Xanax, Zoloft and Dilaudid become something to wear, rather than something to swallow. As rings, pendants and earrings, the medications become icons of wellness, addiction and corporate involvement in health, specifically the health of women.

Those interested in Wolstenholme's work include lawyers representing pharmaceutical giant Pharmacia & Upjohn. They worry about the trademark infringement Wolstenholme is accused of committing when she reproduced one of their products, the tranquillizer Xanax.

In addition to asserting sole rights over trademark, a letter to Wolstenholme from Pharmacia & Upjohn's Canadian lawyers states that Wolstenholme's activities will "cause confusion" between the pharmaceutical company's products and those of Wolstenholme (her jewelry is offered for sale over the internet).

The artist dismisses these claims, saying, "I believed they were trying to curtail my freedom of speech." If someone confuses her jewelry with a real medication, Wolstenholme says, "I can't be responsible for the lowest common denominator." While acknowledging that she is "trying to be provocative," she states that making affordable jewelry is a way to bring art to a wider audience outside the art community.

Within the Canadian art community, Wolstenholme is known for her torso-sized plaster-cast reproductions of medications. These, featured in the cover article of the February-April issue of the magazine *C: international contemporary art*, include Xanax, on a scale large enough to make it look like oversized blocks made for children, and Valium, with its attractive cut-out "V" design. Even more than her jewelry, these large sculptures portray each medication as a meticulously designed object aimed to maximize compliance by being attractive, distinctive and easy to swallow.

In Wolstenholme's opinion, women's widespread use of prescription drugs to treat such conditions as depression is due to women's subjugation by the dominant male culture and a consistent view of women as objects rather than as people.

Medications, even ones that ease depression, are seen by Wolstenholme as expressions of confinement, of further domination.

By making jewelry from these pills, the very icons of confinement, Wolstenholme seeks to turn the power relationship on its head to allow women to acknowledge their often medicated state. As she points out, "One of the reasons that I made the jewelry is because I wanted to wear it. I didn't want to feel bad about taking these drugs."

Tim Turnbull, a Pharmacia & Upjohn spokesperson, questions whether the jewelry can be seen in the same light as the rest of Wolstenholme's work given that she is offering the work for sale. "If people are making a political statement, they are going to go ahead and do it



Colleen Wolstenholme, *Pills*, 1998

and we can't say much. A commercial venture is a different thing."

While the situation may yet become an issue for courts to decide, Wolstenholme's work is part of an ongoing debate concerning the disproportionate use of psychoactive medications by women. The 1997 *Canadian Profile: alcohol, tobacco & other drugs*, the annual comprehensive report on substance use in Canada published by the Centre for Addiction and Mental Health and the Canadian Centre on Substance Abuse, notes that 56 per cent more women than men use tranquillizers (5.3 per cent versus 3.4 per cent). Even more striking is the fact that more than twice as many women than men use antidepressants (4.2 per cent compared to 1.7 per cent). **ANDREW JOHNSON**

Genetic link to panic disorder discovered

CANADIAN SCIENTISTS IN OTTAWA AND TORONTO HAVE discovered a gene that leaves a person susceptible to panic disorder, a psychiatric condition in which people experience frequent episodes of severe panic attacks. This disorder affects up to two million Canadians at some point in their lives, and occurs twice as often in women as it does in men.

Drs. Jacques Bradwejn and Diana Koszycki, of the Royal Ottawa Hospital, found that injecting the hormone cholecystokinin (CCK) into patients susceptible to panic attacks caused an abrupt onset of a panic attack. Building on the work of these researchers, Dr. James Kennedy and his colleagues in the Neurogenetics Section of the Centre for Addiction and Mental Health dissected the CCK system using molecular genetic techniques. They examined the gene for the CCK hormone, and the genes for the two receptors, CCK-A and CCK-B. Dr. Kennedy's

group discovered that a particular variant of the CCK-B receptor gene occurred at a higher rate in the panic disorder subjects.

The gene variant is a susceptibility factor that is easily measured at the DNA level, but it does not definitively indicate that a person will develop panic disorder. The gene variant is present in approximately 20 per cent of the general population, and only three per cent of the population suffers from panic disorder, which suggests that this gene variant works in combination with other genetic or environmental factors to cause panic disorder.

Although the new development does not have an immediate impact on treatment or diagnosis of this condition, it is another important piece in the very complex panic disorder puzzle. If these results continue to be consistently found in other samples, the genetic information may be useful in developing and choosing appropriate medication, identifying individuals at risk for panic disorder and developing prevention strategies.

A study of the two teams' findings is published in *Molecular Psychiatry*, No. 4, 1999. **CHRISTA HAANSTRA**

WHO calls for tougher cigarette regulations

THE DIRECTOR GENERAL OF THE WORLD HEALTH ORGANIZATION (WHO) says that cigarettes should be regulated under the same rules that apply to pharmaceutical nicotine and other drugs.

At the Ninth International Conference of Drug Regulatory Authorities, held in Berlin this spring, Dr. Gro Harlem Brundtland urged the world's food and drug regulators to ensure public health and safety standards by rationalizing rules that govern all forms of nicotine consumption.

"A cigarette is a euphemism for a cleverly crafted product that delivers just the right amount of nicotine to keep its user addicted for life before killing the person," she added.

WHO figures show that today tobacco kills four million people, more than 70 per cent of whom live in developing countries.

Scientist Joanna Cohen, of the Ontario Tobacco Research Unit (OTRU), is supportive of the WHO initiative, saying that regulation plays an important part in the fight against smoking, but that educational campaigns and smoking cessation programs are also important.

"The World Bank has recently stated the most effective anti-smoking measure is to increase taxes on cigarettes," she says. "The Bank also stated that increasing taxes would not have negative spin-offs on the economies of most nations."

A report called *Actions will speak louder than words*, issued this past February by the Expert Panel on the Renewal of the Ontario Tobacco Strategy reveals that the social and economic costs of tobacco in Ontario are \$3.7 billion (1992), much higher than the forecasted \$475 million (1998-99) in provincial revenue that comes from tobacco taxes.

What especially bothers scientists like Cohen is that governments place

stricter regulations on stuffed toys than on tobacco products. Cohen also laments that tobacco companies can pass their "lighter" cigarettes as healthier products, a point that Dr. Brundtland also raises in her speech.

Dr. Brundtland calls the marketing of light cigarettes a camouflage designed to fool smokers into thinking that the products they consume are not as dangerous as full-strength cigarettes.

"Well what is a light cigarette?" asks Cohen. "Light and mild cigarettes are designed with filter holes to allow for the tobacco smoke to be diluted with air before it enters the mouth, but that's not always the case. These products don't come with an instruction manual, so people who block the holes with their fingers or in some other way are getting the same amount of tar and nicotine as smokers using a regular filter, but they may believe otherwise."

OTRU statistics show that 70 per cent of Ontario smokers smoke a light or mild brand of cigarettes.

On May 31, Canadian Health Minister Alan Rock announced the creation of a blue ribbon panel of North American science experts to help develop more effective ways both to regulate tobacco products and to evaluate aids such as nicotine patches and nicotine chewing gum to help people quit smoking.

Health Canada has already increased the accessibility and use of nicotine replacement therapy by making it available without a prescription. Rock indicated that his department will look at the possibility of fast-tracking the approval process for new non-smoking medications and announcing tough new labeling requirements for tobacco products.

ANGELA BIANCHI

Marijuana policy changing

FOR THOSE WHO FOLLOW THE DEBATE OVER THE LEGAL status and use of marijuana in Canada, the first half of 1999 has been eventful.

Responding to questions from the Opposition on March 3, Health Minister Alan Rock made a surprise announcement that his government would begin clinical tests designed to assess the medicinal value of marijuana. While much of the current evidence about marijuana's medicinal effects is either inconclusive or anecdotal, the success of these tests will largely determine whether or not the Canadian government will, in the near future, supply safe pot for those who require it for medicinal reasons.

After almost a four-year legal battle, on May 10 the Ontario Superior Court awarded Toronto social activist Jim Wakeford the right to grow and smoke marijuana, the appetite-stimulating effects of which allow this terminally-ill AIDS patient to counter some of the side-effects of his anti-viral medication. Shortly after that ruling, Alan Rock decided not to contest the court's finding — an act that hastened the call to begin the proposed clinical trials, and allowed for clearance to use the drug for the estimated 20 people who had applied for medical exemptions to the country's marijuana laws.

The Canadian federal government then announced that it was preparing for a series of three trials that would begin to scientifically explore the potential medicinal use of marijuana.

The first series will be undertaken to determine if marijuana has a direct therapeutic effect on AIDS. These trials, to be administered by the Community Research Initiative of Toronto and the federally funded HIV Trials Network, will use marijuana from Mississippi.



(Canadian-grown marijuana was not available for the start of the study.)

A second trial will see the testing of a liquid form of marijuana, in a device similar to that of an asthma inhaler. It is hoped that this device will allow users to reap the anticipated benefits of the drug without getting high or being exposed to potentially cancer-causing smoke.

A third set of trials, to be overseen by the Medical Research Council, will be based on submissions from Canadian scientists who want to study marijuana in any form on AIDS patients, those suffering from the symptoms of chemotherapy or anyone suffering from a disease in which anecdotal evidence of pot's therapeutic value has been shown.

While the debate over the medicinal value of marijuana continues, steps are being taken to keep the drug's recreational users out of the courts.

In April, the Canadian Association of Chiefs of Police endorsed a policy favouring the decriminalization of marijuana. Opposed to the drug's legalization, the Chiefs support a scenario in which certain offences related to possession of small amounts of the drug would not incur a criminal record. Such a policy would be balanced with corresponding initiatives by the federal government to stop or prevent the use of marijuana, such as the provision of better education, enforcement, counselling, treatment, rehabilitation and diversion programs. **CHRIS HENDRY**

Research Update

Ethnic and gender differences in adolescent drug use

In a study of 2,622 African-American, Mexican-American, and European-American seventh graders, U.S. researchers examined the relationship between ethnicity, gender, drug use and resistance to drug offers. They discovered that all groups lacked large and sophisticated refusal-to-offer strategies; drugs were more often offered by acquaintances than by friends; and ethnicity played a significant role in drug usage and the refusal process. According to the writers, Mexican-Americans received more offers and consumed more drugs; European-Americans were more likely to be offered drugs by an acquaintance, at a home of a friend or on the street; and African-Americans were more likely to be offered drugs from dating partners, parents and in parks.

Substance Use & Misuses: An International Interdisciplinary Forum, v. 34, 1059–1083. Dreama G. Moon et al., Arizona State University, Tempe, Arizona.

Mental health and social adjustment in refugee children

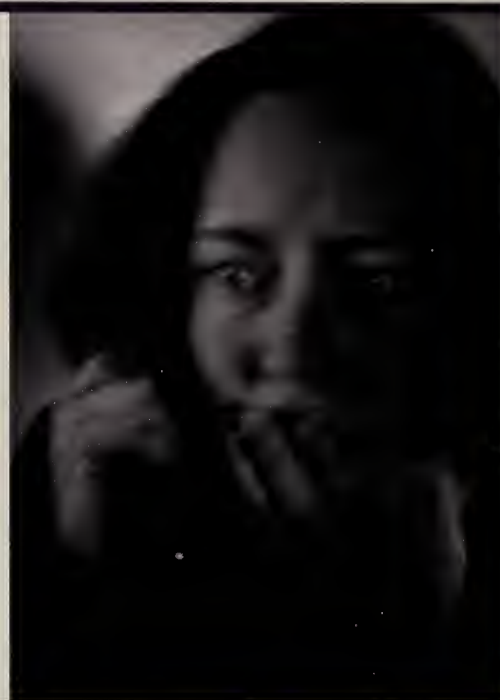
Conducting a longitudinal study on the mental health of refugees, Swedish researchers evaluated 50 preschool Iranian refugee immigrants 12 months after they arrived in Sweden, and then re-evaluated 39 of the original respondents 2 1/2 years later. They found that individual vulnerability and exposure to war and political violence was a predictor of long-term post-traumatic stress disorder symptoms in children. Emotional well-being in children was also found to be predicted by the emotional well-being of the child's mother, while social well-being of children was largely dependent on the quality of their peer relationships. From these results, researchers concluded that adaptation of the refugee child to the host community is a composite of many factors, including peer relationships and bullying, which can play as large a role in children's emotional well-being as their previous exposure to war and violence.

Journal of the American Academy of Child & Adolescent Psychiatry, v. 38, 723–730. Kjerstin Almqvist et al., Centre for Public Health Research, University of Karlstad, Sweden.

The psychological impact of stalking

In an effort to systematically assess the psychological impact of stalking on female undergraduates, 36 women who had been victims of stalking were compared with 43 women who had been harassed and 48 controls. Measuring emotional impact on three scales — the Post-Traumatic Stress Disorder (PTSD) Scale, the Symptom Checklist-90-R, and the Self-Report Interpersonal Trust Scale — researchers determined that victims of stalking experienced significantly more PTSD symptoms than did victims of harassment or control subjects.

Journal of Forensic Sciences, v. 44, 554–557. Darrah Westrup et al., Department of Psychology, West Virginia University, Morgantown, West Virginia.



Measuring depression among African-Americans

Though unemployment rates of African-Americans in the U.S. are more than twice that of the white population, researchers have discovered that differences between unemployment and employment were less significant for predicting depression in the African-American population than in the white population. Health-enhancing factors such as wealth and education, significant in the white population in determining levels of depression, were of inconsistent significance for the African-American population. Researchers concluded that conventional wisdom regarding the causes of depression is not necessarily transferable over racial lines. They recommended that future studies examine the special needs and circumstances of African-Americans, as currently available protective factors may not have the intended impact.

Journal of Epidemiology & Community Health, v. 53, 335–342. Eunice Rodriguez et al., Department of Policy Analysis and Management, Cornell University, Ithaca, New York.

Adolescents, movie stars and smoking



Researchers at the Cancer Prevention and Control Program at the University of California at San Diego have found that movie stars who smoke on and off screen may play a role in encouraging adolescents to smoke. Based on the results of the 1996 California Tobacco Survey that asked 6,252 adolescents to discuss such topics as their favourite stars and smoking history, this study showed that “ever” smokers (as compared to “never” smokers — those who had never had a cigarette) were more likely to rate actors who smoked on and off screen as their favourites.

Preventive Medicine, v. 28, 1–11. Janet M. Distefan, Cancer Prevention and Control Program, Cancer Centre, University of California at San Diego, La Jolla, California.

Ethnic identity and self-esteem in Native adolescents

Because Native youth are at a high risk for a variety of poor outcomes, such as substance abuse and suicide, a recent study at the Centre for Addiction and Mental Health looked into the impact of cultural identity conflicts on youth's mental health. Examining a general hypothesis that directly links ethnic identity to Native adolescents' self-esteem, researchers surveyed a group of 164 Native Grade 10 and 11 students. Contrary to their expectations, the scientists found that self-esteem was not related to the strength of adolescents' identification with the Native culture, but rather to the strength of their identification with the dominant white culture. From this result, researchers concluded that the best way to nurture Native adolescents' self-esteem is to help them to cope with the demands and prejudices that may be inflicted by the dominant culture.

Unpublished study, 1999, Andy Gotowiec et al., Centre for Addiction and Mental Health, Toronto, Ontario.

The impact of New York City's Smoke-Free Air Act

When studying the consumer response of New York City's Smoke-Free Air Act, which prohibits smoking in restaurants, researchers discovered that the vast majority of respondents were either unaffected by the 1995 law or had begun to dine out more frequently since the law had been passed. Furthermore, they found few reports of consumers who stopped eating out or chose to leave or enter the city to eat in a restaurant that suited their smoking habits. They concluded that the Smoke-Free Air Act has had very little impact on the dining-out patterns of consumers.

Journal of Public Health Management Practice, v. 5, 28–36. Andrew Hyland et al., Department of Cancer Control and Epidemiology, Roswell Park Cancer Institute, Buffalo, New York.

Drinking and binge drinking in college students

Researchers at the University of New Mexico examined the drinking patterns of 2,710 college students at a large Southwestern U.S. university from 1994 to 1996 inclusive. They discovered that 80 per cent of respondents at each interval were current drinkers, while one-third of the students at each time period reported binge drinking behaviours. Binge drinking (defined as consuming four or more drinks at one occasion for women, five for men) is a behaviour known to be associated with such harms as property damage, missed classes, unplanned and unsafe sexual activities,

and increased rates of drinking and driving. This study shows that, rather than delivering blanket messages about the harms of drinking, interventions geared toward students should be tailored more to address the harms of individual binge drinking patterns.

The American Journal of Drug and Alcohol Abuse, v. 25, 331–350. Melanie E. Bennett et al., Department of Psychology, The University of New Mexico, Albuquerque.



Male and female adolescents and eating disorders

Although eating disorders are known to appear most commonly in female adolescents and adults, adolescent males account for 30 per cent of the eating disorder population of their age group (as opposed to adult males, who account for 10 to 15 per cent in their age group). Though there is little clinical difference in features of eating disorders between the sexes at the adult level, it is unclear whether the available literature is transferable to the experience of adolescents. Researchers at Toronto's Hospital for Sick Children studied a group of male and female adolescents, upon their first visit to an eating disorder program, to examine possible differences in such factors as individual psychopathology and perception of family functioning. Though their results suggest that male and female adolescents with eating disorders are clinically similar (and therefore comparable to the lack of gender-specific clinical differences of adults), researchers recommended that further study of gender differences of adolescents with eating disorders needs to be pursued.

The Canadian Journal of Psychiatry, v. 44, 374–378. Rose Geist et al., Medical Psychiatry Program, Department of Psychiatry, The Hospital for Sick Children, Toronto.

Prenatal alcohol consumption and child size

In a longitudinal study at a prenatal clinic, researchers explored the effects of prenatal exposure to alcohol. Though the mothers in this sample group were predominantly light-to-moderate drinkers, the sample represented the entire range of drinking patterns. Researchers measured the weight, length, head circumference and skinfold thickness of 610 babies at delivery, at eight and 16 months, and at three, six and 10 years of age. At age 10, those children who had prenatal exposure to alcohol were significantly smaller (in proportion to the amount of alcohol consumed) in each of the categories studied than were those who were not exposed to alcohol. From these results, they concluded that prenatal alcohol exposure can have a long-term effect on child growth.

Alcoholism: Clinical and Experimental Research, v. 23, 863–869. Nancy L. Day et al., Department of Psychiatry and Epidemiology, University of Pittsburgh, Pittsburgh, Pennsylvania.



Fire and Reason

New publication features the work of young people with mood disorders

BY SUE McCLUSKEY

IT'S A WARM SPRING EVENING AT THE Free Times Café in downtown Toronto, but this is not an ordinary "open-mike" poetry night. The audience of about fifty people is there for the launch of *Fire and Reason*, a new "zine" that features the writing and artwork of young people with mood disorders.

Young writers, mostly university age, some clean-cut, some dressed in "grunge" gear, come on stage, one by one, to read poetry, fiction and excerpts from plays.

'Zines started out as small home-made music magazines called fanzines — now, they cover anything from art to politics. Inexpensive, accessible, and with a hip do-it-yourself attitude, their grassroots appeal has won them solid favour in youth culture.

The first issue of *Fire and Reason* is 48 pages, photocopied and stapled together on plain paper. The inside artwork is a combination of cut-and-paste images and different-sized type, which delivers the "alternative" flavour that is characteristic of the format. It is distributed through the usual 'zine channels: a mail-out, then single-copy sales primarily in record stores and used bookstores.

Its content is a lively blend of subject matter and styles, from fast-paced first-hand critiques of the effects of psychiatric medications to reflections upon failed relationships.

Ariadne Patsiopoulos, 27, is the founder, editor and publisher of *Fire and Reason*. She says that she started the 'zine as a forum for young people with mood disorders — a forum that she, diagnosed at 19 with bipolar disorder, never had.

"I really desperately needed to find something other than text books or self-help books that could clarify things for me and help me understand my experiences better. I've looked around since then, and up until this point, I haven't been able to find anything, and there's such a need," she says.

For her, writing was a necessary part of every day. When she was hospitalized, she says, "I remember just feeling that the only way I could deal with each day was to sit down in

the lunch room on my own, and I'd just write.

"I think that it was an anchor; I think that it was a way for me to understand what exactly was going on with me, but at the time I didn't really understand why I was in hospital."

The first issue features the work of 15 contributors who heard about the project by word-of-mouth, newspaper and magazine ads, and posters. In her editorial, Patsiopoulos (who is currently studying publishing at Ryerson) asks people to "make art with our tears, pills and ambulance bills."

Apparently, they did just that; she says she was amazed at the response to the call for submissions for the first issue, which came from as far east as Nova Scotia and as far west as British Columbia. Based on what she's seen, she says, "I think that young people have a lot of really insightful and great and powerful things to say."

"Why don't we make art with our tears, pills and ambulance bills."

— Ariadne Patsiopoulos, editor, *Fire and Reason*

Matthew Flynn, an 18-year-old poet from Lime House, Ont., has been writing since he was 13. Since he was diagnosed with attention-deficit disorder-depression, he says that writing has helped him to get perspective on his moods.

"When I write down the things that I feel, and then I look at it, it's like reading a story in the third person," he says. "Usually it's easier to figure out someone else's problems than your own. It's like approaching it from the back door."

Along with the self-esteem boost of seeing his own work in print, Flynn, like many others, is aware of how telling his experiences in poetry can help people in similar situations.

The 'zine, he says, is a great way "to share, to let people know that they're not the only ones feeling that way. It's good just to tell people that writing things down helps to figure things out."

Though she has the support of office

materials from the Mood Disorders Association of Ontario, in Toronto, Patsiopoulos funds *Fire and Reason* out of her own pocket.

The rewards, however, are great.

"Sometimes I get letters that read, 'Thank you so much for doing this,' or, 'I really hope that your project manages to continue, because what you're doing is invaluable,'" she says. "Those instances make me feel so good. Just walking into that room at the launch made me feel so happy that all these people could gather in one room together to share common experiences."

"One mother thanked me afterwards, saying, 'I think this will encourage [my son] to continue on with his writing.'"

The theme for the fall issue of *Fire and Reason* is stigma. To submit work or to order copies (\$2.00), contact *Fire and Reason* by e-mail at: <Fire_Reason@yahoo.com> or by telephone: (416) 760-2129. For a sample of the first issue, look up their web site at: <www.geocities.com/SoHo/Village/5990/firereason.html>. ■

Joyful Thoughts of Depression

*When I feel like crying
I weep tears of joy*

*When I get angry
I really love to hate*

*When I feel like shouting
I yell loud silences*

*In this unfair world
We all live to die*

Matthew E. Flynn, 18,
from *Fire and Reason*, issue 1

Disorder of Discontent

Dysthymia often goes
ignored or undertreated

BY DIANA BALLON

SARA* HAS NEVER FAILED A YEAR OF school, nor has she ever lost a job. In fact, she's never failed significantly at anything. But at the same time, she's never seemed to live up to her potential. Her jobs have all been below her ability, her relationships have fizzled after a few months, and her lack of self confidence has prevented her from seeking out the people and work opportunities that would make her more satisfied.

Sara has "dysthymic disorder" — a chronic, low-grade depression that usually begins in childhood or adolescence and, according to the DSM IV definition, persists "for more days than not" for at least two years in adults, or one year in children. Adult sufferers tend to "describe their mood as sad or 'down in the dumps,' " while children may be "irritable rather than depressed." To be diagnosed with dysthymia, a person must have at least two of the following: poor appetite or overeating, insomnia or sleeping too much, low energy or fatigue, low self-esteem, "poor concentration or difficulty making decisions" and feelings of hopelessness.

While these symptoms resemble those of major depression (which 90 per cent of sufferers will experience at least once in their lives), they differ in that dysthymic symptoms tend to last longer, begin at a younger age, and be less severe.

If untreated, dysthymic disorder can last for years or even decades, says Dr. Michael Thase, a professor of psychiatry at the University of Pittsburgh School of Medicine and one of the leading experts on the topic. Speaking to health professionals at a recent conference on dysthymia in Toronto, Dr. Thase stressed the importance of treating this long-neglected and limiting disorder, which affects an estimated three to five per cent of the population. He says the prevalence is three times greater in women and at least three to five times greater among those with a family history of depression.

Dysthymia significantly limits people's quality of life. It's as disabling as major depression and congestive heart failure and is more disabling than diabetes or peptic ulcer disease,

Dr. Thase says. A startling 35 to 40 per cent of people with dysthymia never marry. Dr. Thase suggests that this may be due to several factors: more than 75 per cent of people with dysthymia also suffer from other psychiatric conditions, such as generalized anxiety disorder, social phobia or substance abuse problems, and most have a pessimistic attitude, and difficulties coping with stress, that can influence their openness to new challenges.

Many people with this disorder spend two to three days per month in bed. The majority are underemployed, miss promotions, fail to meet deadlines and are often absent from work.

Despite the troubling effects of this condition, many sufferers go untreated.

"In the early days, there was the view that severity trumps chronicity," says Dr. Zindel Segal of the Cognitive-Behavioural Therapy (CBT) Unit at the Centre for Addiction and Mental Health, who also spoke at the conference. This view has meant that greater attention has been given to major depression, because of its more severe symptoms, despite the fact that the chronicity of dysthymia actually costs more in terms of workplace absenteeism and results in greater social disruption in the patient's life, Dr. Segal says.

Despite evidence about the biological basis of dysthymia, only about 50 per cent of sufferers get antidepressant treatment for their condition, treatment that is often unsuccessful or discontinued. Many people still view the symptoms of dysthymia as personality traits (such as a propensity to complain or to be discontent), rather than as the result of a mood disorder. People also tend to underappreciate the benefit-to-risk ratio, Dr. Thase says, and they operate from the belief that "if it's only moderate, why bother?"

Dr. Thase recommends that patients who respond well to an antidepressant stay on the medication for six to nine months and then, according to their life circumstances, consider discontinuing gradually. He says the risk of relapse after stopping medication is approximately 50 per cent within six months. For those

who remain on medication, there is about a 10 per cent risk of relapse per year. Despite these statistics, it is not clear if people with dysthymia should expect to take medication for a lifetime, he adds.

An alternative or adjunct to medication is psychotherapy. Cognitive-behavioural therapy (CBT) and Interpersonal Therapy (IPT) have proven to be particularly effective in treating various forms of depression, because of their pragmatic approach; the underlying theory behind CBT and IPT is that thoughts and feelings are inextricably linked and that patients can learn to understand, challenge and thus control their negative thinking, which will in turn affect their moods. According to a recent study by Dr. Segal, once someone has been successfully treated for depression, continuing CBT can be more effective in preventing future relapse than antidepressants.

For Sara, a combination of CBT and a low-level dose of Paxil has made her able to concentrate better, and thus be more productive at work. She says she feels less stressed and has more energy to get involved in outside activities, and has easier, less conflictual relationships with family and friends. For the first time in her life, Sara is in a committed long-term relationship and, most importantly, she says, "I am happier now than I ever have been before." ■

**not her real name*



New report looks at risk factors in child poverty

A FAMILY OF FOUR IN CANADA NEEDS to earn between \$30,000 and \$40,000 a year if the children are not to be damaged by poverty, according to a recent study released by the Canadian Council on Social Development (CCSD).

"Where you set the poverty line is going to have an impact on the future well-being of a child," says Paul Roberts, co-author of a report called *Income and Child Well-being: a New Perspective On the Poverty Debate*.

"If you look at low income levels below that range [of \$30,000 to \$40,000], there tends to be much less opportunity for good health care, learning and behavioural outcomes," says Roberts, a research associate with the CCSD.

In the report, Roberts and his co-author, CCSD executive director David P. Ross, write, "we believe that the objective of anti-poverty efforts and measures should be to reduce the enormous inequality of opportunity..."

According to Statistics Canada, there are about 1.5 million children living in poverty, with the low income cut-off figure falling at about \$27,000.

The report studies 27 elements of child development, including family functioning, neighbourhood safety, aggression, health status, math and vocabulary scores and participation in extra-curricular activities. The report concludes that in "80 per cent of the factors examined, child outcomes improved substantially as annual family income rose towards \$30,000. In 50 per cent of the factors examined, this trend continued steadily as family income rose to \$40,000."

The study notes that beyond this upper range, improvement for the child continues but the rate of change is not substantial.

"That is not to say that a child from a low-income household cannot possibly do well," says Roberts. "But each of these elements were affected proportionately by income levels."

Dr. Leslie Atkinson, deputy head of the Child Psychiatry Program at the Centre for Addiction and Mental Health, explains the significance of the report's type of qualitative research. "The implications of poverty are that the child is living under not one but multiple risk factors."

He says that children are naturally adaptable and "deal very well with one or two stressors in their lives." He adds, however, that "it is the multiple stressors that create problems."

Roberts says some of the impetus for conducting this study is the heated debate currently going on about poverty and whether basic subsistence level incomes are adequate in Canada, "which, after all, is not a Third World country."

"It's apple pie to say we need to put resources into impoverished families, but the implications are very obvious," says Dr. Atkinson, adding that, in anti-poverty efforts and measures, "finances are one thing, but you have to put other supports in place, such as day care, parenting support" and other environmental factors such as decent housing.

Based on observations he has made in his clinical practice, Dr. Atkinson says he has seen that, "with higher-income families you can often get away with a single treatment modality, such as just family therapy, but with an impoverished family you need to put in broader supports."

Paraphrasing another adage, he concludes, "if you spend money earlier, eventually you spend less later."

The report is available on the internet at: <<http://www.ccsd.ca/>>. KALYANI VITTALA

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The umbrella of diversity covers all aspects of difference — from race to culture, ethnicity, gender, age, abilities, religion and sexual orientation. In this issue of *The Journal*, our Focus section explores one aspect of diversity: ethnocultural issues in the mental health and addiction fields.

The language of care

Ethnic groups face many barriers to mental health treatment

BY ANITA DUBEY

AS DIFFICULT AS IT IS TO COPE WITH A MENTAL HEALTH problem, the struggle compounds if you can't speak the native language well enough to get help.

That's the reality for many immigrants and refugees who are adjusting to life in Canada. But at the Hong Fook Mental Health Association in Toronto's downtown Chinatown, staff who speak Chinese, Vietnamese, Cambodian and Korean ensure that people from East Asian communities don't have to struggle to be understood.

While language is the most obvious barrier facing ethnic groups who need mental health services, many other factors prevent them from getting the same care as those in the mainstream population.

It took the tragic shooting death of Edmond Yu to bring the issue of culturally-sensitive mental health care to wide public attention. Yu, who had schizophrenia, was shot by police in 1997 during a confrontation on a Toronto bus.

Earlier this year, a coroner's jury into his death recommended better training for psychiatrists in treating ethnic patients, and funding for groups to provide services to ethnic communities.

These needs have long been recognized by service providers working with these communities. Many studies have shown that ethnic or racial groups entering the medical system may be treated differently and inappropriately compared to the mainstream population. For example, Dr. Morton Beiser, head of the Culture, Community and Health Studies Program at the Centre for Addiction and Mental Health, notes that studies have shown that people who don't speak English have less chance of being referred to a specialist.

"Even something that seems as culture-free as medication is not," says Dr. Beiser. Asians, for example, may be more sensitive to antipsychotic medications, and some studies suggest that people of African or Caribbean heritage are overdiagnosed with schizophrenia.

A few organizations have sprung up to fill the void. Across Boundaries was created in 1995 in Toronto. Operating under an anti-racism framework, it serves people from ethnoracial groups with severe mental health problems or illnesses. And in the United Kingdom, Asian women were found to be treated with shock therapy and antidepressants more often, says Martha Ocampo, co-director of Across Boundaries.

"We feel people don't have choices," says Ocampo, who also co-founded the organization. "The whole idea of spirituality has no place in Western medicine. But it's important for many people in different cultures as part of their healing."

The multicultural staff of Across Boundaries take a holistic approach, integrating alternative therapies such as yoga, acupuncture, ayurvedic medicine and art therapy into the programs it provides.

The organization has more than 90 clients, including people with Caribbean, African, South Asian and East Asian backgrounds. In addition to case management services, the organization provides group sessions, computer training and a community kitchen. It is funded by the Ministry of Health.

Hong Fook's history dates back to 1979, when a group of Chinese professionals met to discuss concerns about access to treatment. Initially, they set up a telephone consultation hotline. Hong Fook received funding from the Ministry of Health in 1982, and has expanded to serve other East Asian communities.

"Our clinical experience is that people benefit more from these services than others, even if they speak English," says Christina Chan, acting executive director.

Prevention and health promotion are an important part of Hong Fook's programming, as well as the consultation, short-term treatment and case management services it provides to consumers and family members. It also offers stress management, support groups and special classes in English as a Second Language for patients who can't keep up with regular classes due to health reasons.

"Hong Fook is like a cultural bridge," says Chan. "Our target group is not only people with mental health problems, but also professionals." While the East Asian community is well-established and has provided a model organization in Hong Fook, the demand for services still outstrips its capacity. It serves 200 clients, but has a nine-month waiting list of people with language difficulties.

Newer groups of immigrants and refugees are usually not in a position to set up such organizations, and funding is scarce. So the current reality for many immigrants or refugees seeking help is still "catch as catch can," says Dr. Beiser.

Specialized organizations, though, are not the only solution. Dr. Beiser even fears their existence may enable mainstream service providers to abdicate their responsibility, by referring clients to agencies such as Hong Fook. "It's not a Chinese problem, not a Hong Fook problem. It's our responsibility as a system," he says.

Simply educating service providers to ask the right questions about a person's background as it relates to treatment helps to transcend cultural barriers, says Dr. Beiser. Well-trained translators are also essential.

Across Boundaries advocates anti-racism training for all mental health professionals as well. "We all have biases, even if you're a person of colour," says Ocampo.

Part of the solution may also lie within different cultural communities. "Many of these communities have well-trained, highly qualified people," Dr. Beiser says. Licensing restrictions prevent them from working, but they could serve as valuable resources if rules were changed.

"The population of Toronto is changing dramatically," warns Ocampo. "If we [as a system] continue to practice as we have before, it won't be as effective."

Substance abuse and cultural communities

Mainstream services
inaccessible to non-English clients

BY CINDY McGLYNN

WITH AN IMMIGRANT POPULATION OF CLOSE TO THREE million people, it's not surprising that access to services in languages other than English is increasingly becoming an issue in Ontario.

In fact, more than half a million people have emigrated to Ontario since 1991. According to the 1996 census, well over half of them have settled in Toronto. And more than a quarter of a million people in Ontario speak neither English nor French. Again, over half of this population is in Toronto.

When it comes to providing essential services — such as treatment for substance abuse — those who wish to offer complete access say the current system is simply not good enough to systematically provide help to people who don't understand the mainstream language or culture of their new country.

Merel Kasebi, Senior Culture and Race Consultant for the Centre for Addiction and Mental Health's central region, puts it plainly.

"In general, you can safely say there is no system for the ethnic communities. They are required to access services through the mainstream system, which doesn't often happen."

Kasebi says that language is the most obvious reason to offer special services, but it is not the only one. Cultural differences come into play as well.

One example is a person coming from an abstinent culture who develops an alcohol dependency while adjusting to a North American tolerance to the substance.

Kasebi says to offer effective treatment, service providers not only need to understand subtleties between cultures, but also need to keep in mind the particular stresses on anyone adjusting to a new culture.

"The whole idea of immigration and settlement can be difficult. People may be coming from very difficult situations, coming into an even more difficult situation. They may not have access to their professions. There are definite stressors. The crux of it is the socio-economic situation they meet with here. They need comfortable and reliable housing. They need to not feel lonely and to work in jobs that they find satisfying. Ethnicity doesn't influence whether or not you drink. It's other factors."

Kasebi says the best solution is to work within individual communities to offer secure and comfortable treatment. Currently, agencies are coping on an ad hoc basis; though there is a long way to go, progress is being made.

In and near Toronto, there is Woodbridge's Vita Nova, where director Franca Damiani Carella offers a highly structured program and pays close attention to her clients' upbringing, including their cultural background. SAPACCY (Substance Abuse Program for African-Canadian and Caribbean Youth), at the Centre for Addiction and Mental Health, works with Caribbean and African-Canadian youth and seeks to offer culture-specific prevention and treatment. A pilot

project from the Centre, called the Chinese Cultural Adaptation program, will adapt a structured relapse prevention program to meet the cultural and linguistic needs of Chinese clients, using Chinese service agencies and members of the community as guides.

Toronto's Ethno-racial Coalition works to bridge the gap between ethnic populations and essential services. Formed in 1997, the coalition's goals are to provide community advocacy and to ensure availability and quality of service to ethnocultural communities.

"It is not only different languages," Enir Bassani, the coalition's chair, stresses. "We need to be able to go to [service] corporations and get them to hire people who speak different languages and are from different cultures. People who will know what Africa represents, what Latin America represents — the different ways of survival and coping."

The Canadian Centre for Substance Abuse (CCSA) database indicates that, in towns and cities outside Toronto, service is also spotty. This database catalogues substance abuse treatment programs across the province and the country, and shows a breakdown by language of services provided. A scroll through the data is enlightening, albeit disheartening. Ottawa has a surprising number of unilingual English services and only a handful that are even bilingual in English and French. Hamilton's Moreland Addiction Treatment Centre stands out, by offering service in English, French, Hindi, Punjabi, Urdu, Portuguese and Italian. But, according to the CCSA material, many more places offer unilingual English service — or English and French at best.

In addition to offering services in English and French, Sudbury's Pinegate Addiction Services has an Italian staff member who can offer service in that language. But Pinegate's interim director, John Scott, says the greater need is addressed by a network of volunteers organized through Pinegate's sponsor, Network North: The Community Mental Health Group, which serves Sudbury and Manitoulin.

This volunteer scheme offers a list of 500 volunteers from among various Health Group organization's staff, including a long list of translators. Scott calls it Pinegate's first line of defence and says the translator could be anyone from a doctor to a dishwasher.

"We're very fortunate we have that," he says.

Bassani, whose coalition recently received Immigration Canada funding to teach front-line settlement workers how to spot substance abuse, doesn't want Ontarians to have to rely on fortune.

"I think all the taxpayers deserve the same opportunities. It is easy to think we are all equal. But you are only equal as long as you speak the language. After that you are probably really neglected. And the service providers must at least hire people from different points of view [who are] able to guide the corporations to be aware of these issues," says Bassani.

"They must do at least that."





Somali refugees vulnerable in Canada

BY CINDY McGLYNN

HISTORICALLY, SUICIDE IS VIRTUALLY non-existent in traditional Somali culture.

Toronto community worker Abdirahman Sabriye says that, as a Muslim people, Somalis commonly turned to their religion for guidance in times of hardship. Misfortune was seen as a way to make amends for past-life misdemeanors. Usually, no matter how great the problem, people found strength and courage.

However, the immigrant Somali community in Toronto, numbering about 50,000, has suffered 22 suicides in the past four years.

That rate is one of the reasons why Community Resources Consultants of Toronto (CRCT) have hired Sabriye to identify the Somali community's mental health needs — to allow that community to start walking a path towards healing.

CRCT, a community mental health agency, was looking for a way to step up services to better serve various ethnoracial communities. When the Family Services Organization (where Sabriye works three days a week) presented CRCT with the opportunity to co-hire a staff-member with them, CRCT manager Kapri Rabin says there was no hesitation.

For the last 10 months, Sabriye has spent one day a week interviewing members of the Somali community. His findings will be presented to the CRCT later this year in a formal report.

Sabriye says one of the biggest problems has been getting people to acknowledge mental illness and accept available treatment, as Somalis are not familiar with Canadian clinical methods of treating mental illness. He also says many Somalis may avoid seeking treatment altogether, for fear of jeopardizing their chances of attaining Canadian citizenship.

Many Somali refugees are classified as "undocumented Convention refugees" by Citizenship and Immigration Canada. Because they lacked proper documentation upon arrival, they must wait five years (as opposed

to the usual six months) to seek landed immigrant status.

All refugees in Canada must pass a medical examination, which may also test for mental well-being. Giovanna Gatti, media spokesperson from Citizenship and Immigration Canada, says that if two doctors think a person is likely to use excessive resources, he or she may be denoted medically inadmissible for Canadian citizenship. She points out that this regulation applies to all refugees, not just Somalis.

Sabriye says the members of the Somali community, aware of their "special" status, react to the regulations by ignoring problems that are inevitable, given the tragic experiences many have had in, and upon leaving, their home country.

"These people have seen war," he says. "The civil war left something in their mind. The suffering. The refugee camps. The loss of many family members. The loss of loved ones. Obviously they had a huge problem when they arrived here."

In Canada, Somali refugees now struggle with additional issues, such as homelessness, addiction and suicide.

"What the community needs is education," says Sabriye, who is planning summer educational workshops encouraging people to take the first steps towards healing — recognizing mental illness and seeking treatment.

"This needs to be thought of as a normal

Ethnic minorities in Toronto

Toronto is one of Canada's most cosmopolitan cities, with more than 48 per cent of its population made up of visible minorities. This is a higher proportion than any city in North America or Europe. By next year, Toronto's visible minorities are projected to be the majority, making up 54 per cent of the population.

Not only are we receiving many, many immigrants to Toronto each year (estimates are in the neighbourhood of 70,000), the origin of these groups is different from what it was in the past. Until the early 1970s, most immigrants came from Europe and the U.S., whereas now these regions of the world account for only a quarter of the 200,000 immigrants and refugees who come to Canada every year. Most of today's immigrants — from Asia, South Asia, the Middle East, Latin America, the Caribbean and Africa — are also "visible minorities."

Approximately 42 per cent of new immigrants destined for Metro Toronto each year speak neither English nor French.

disease, which can happen to anyone. It is not a choice. The sooner you go the hospital, the more chance you have to get help. If it is too late, it might be very difficult to cure the disease."

NOTICE

The Board of Directors of the Jellinek Memorial Fund is pleased to announce that the Jellinek Memorial Award has been awarded jointly to Drs. Kaye M. Fillmore (Institute for Health and Aging, Department of Social and Behavioral Sciences, UCSF, San Francisco, CA) and Alexander Wagenaar (Alcohol Epidemiology Program, University of Minnesota, School of Public Health, Minneapolis, Minnesota).

The award consists of \$5,000 and a bust of the late E.M. Jellinek.

The category for next year's award is "Biological and medical research." Send nominations by Sept. 1, 1999, to the chair of the Selection Committee, Dr. Charles S. Lieber, Director, Alcohol Research Center, VA Medical Center (151-2), 130 West Kingsbridge Road, Bronx, NY 10468-3922, USA.; fax: (718) 733 6257, e-mail <liebercs@aol.com>.

Q & A

Common questions about ethnocultural diversity



What are some barriers to care that ethnic minorities face?

Despite Canada's policy of equal access to care, significant barriers still exist due to language, culture and ethnicity. Most programs in Canada rely on verbal communication in English, are geared to the middle class, and are based on Western values and concepts of socialization, child development and family structure.

As a result, many people from ethnocultural communities may not use existing services, perceiving that care is not responding to their needs or that their need for help reflects an illness too shameful to acknowledge. Depending on community and family beliefs, some people from ethnic minorities may prefer to speak to a family member, friend, religious leader or traditional healer, rather than seek out a health professional.

A study conducted by members of the Culture, Community, and Health Studies (CCHS) Program of the Centre for Addiction and Mental Health (CAMH) found that Chinese families waited far longer than Canadian-born families to bring a family member with psychotic symptoms to the attention of the mental health care system. Delay in seeking treatment may be related to fear of stigma, which is, in turn, based on the concept that severe mental illness is hereditary. Disclosure could compromise marriage prospects for the siblings and/or children of a person afflicted with psychosis.

Minority groups may also hesitate to seek access to care due to distance, cost, lack of information on how to find services, perceptions of racism, lack of awareness of foreign language-speaking physicians and a lack of trust in professionals. Immigrants may have less opportunity than their Canadian-born counterparts to take time off from work to seek medical attention when they need it.

How prevalent are addiction and mental health problems?

There is only limited data regarding the prevalence of mental disorders in immigrants/refugees in Canada — some of it conflicting. In general, the older research literature suggests higher rates of mental disorder for foreign as compared with native-born; literature after the 1970s suggests the opposite. For example, a study by members of CCHS demonstrated that refugees from Southeast Asia had lower rates of major depressive disorder than native-born Canadians.

The Ontario Child Health Survey and Statistics Canada's National Longitudinal Study of Children and Youth (NLSCY) both show that, on the whole, immigrant children have fewer mental health problems than their native-born counterparts. Analysis of NLSCY data by CCHS investigators reveals that, while poverty is a risk factor for all children, and immigrant families are poorer than native-born families during the first ten years of resettlement, immigrant children living in poverty have a lower risk of mental health problems. Why? Because Canadians living in impoverished conditions are more likely to come from dysfunctional families and/or families headed by a parent(s) with a mental illness — conditions that may compromise the ability to offer optimal parenting. Poverty for immigrants, on the other hand, tends to be linked to external circumstances such as resettlement, rather than emotional instability. Many might argue that immigration itself reflects emotional resilience and resourcefulness.

The majority of today's immigrants to Ontario come from Asia, from countries with low rates of alcoholism. Although the rate of problem drinking among immigrants is initially low, studies by CCHS researchers indicate that drinking problems tend to increase the longer immigrants live in Canada. As immigrants become more acculturated, they apparently tend to pick up some of the host country's bad habits.

What are the difficulties in assessing ethnic minorities for addiction and mental health problems?

The clinical interview is the main tool used to assess addiction and mental health problems — and yet this tool may not always be reliable. Differences among communities in terms of language, beliefs and customs may result in the clinician misunderstanding the client, and vice-versa. Victims of torture might speak dispassionately about their experiences as a way to cope with extreme stress. Asians and Hispanics might talk about the physical rather than psychic symptoms of stress — describing headaches and stomach pain, for instance — and only revealing suicidal thoughts when asked about them directly. Interpreters may inadvertently contribute to the communication problem by softening or downplaying questions they deem inappropriate.

Practitioners may also apply cultural-specific norms to a client or group, when a more general

or universal norm may be more appropriate. For instance, a third-generation Chinese woman with a university education might respond more similarly to Canadians of European descent than someone who has just arrived in Canada.

What are some ways to make care more accessible?

Providing cross-cultural services is a challenging process, requiring continuing training and education of counsellors, development of culturally-appropriate assessment instruments and challenging of practitioners' unconscious assumptions or biases.

Training should avoid stereotypes, such as depicting immigrants in less prestigious positions, and should instead focus on exposing practitioners to actual experiences in the field. Health care professionals should become more comfortable asking questions about the attitudes and beliefs of their clients. Clinicians might, for instance, ask:

- Do you have a word for this condition at home?
- How would this be treated in your home country?
- What do you think might have caused your condition?
- What does it mean to be an immigrant?
- What does it mean to be a refugee?
- How many generations has your family been in Canada?

Clinicians should also be trained to work more effectively with interpreters. An interpreter might, for instance, suggest to the clinician that a question be reworded more appropriately, to respect how the client might react. Interpreters could, in turn, be trained in the technical language of addictions and mental health, and guided to overcome their natural protective instincts to soften potentially uncomfortable comments made by practitioners.

Finally, ethnocultural communities need to be represented on boards of hospitals, in senior faculties of universities and in other influential positions; such representation will go a long way in dispelling cross-cultural assumptions.

Sources: Dr. Morton Beiser, Culture, Community and Health Studies Program, CAMH; Mental Health and the Italian Community, Doctor's Hospital, Toronto; Encyclopedia of Mental Health, Vol. II; Growing Up Canadian – A Study of New Immigrant Children, CAMH; The Toronto Star Beyond 2000 series, 1999.

HIV clients and concurrent disorders

THE ASSESSMENT AND TREATMENT OF people with HIV who have co-occurring addiction and mental health problems can challenge and befuddle even the most experienced and holistic of helpers.

The Alcohol and Drug Wildcard: Substance Use and Psychiatric Problems in People with HIV, by Joan E. Zweben and Patt Denning, covers a lot of ground, offering a very tidy introduction to the subject of "triple disorders."

One section of the book, on assessment and diagnosis, provides a handy schema for planning care, looking at determining safety, stabilization and maintenance issues in three problem domains (HIV disease, psychiatric problems and substance use).

The brief overview defining addictions is as good a synopsis as I have come across in such a few pages, highlighting the evolving ways we have been challenged to look at the definition of addiction over the past three or four decades.

Briefer sketches are offered of psychiatric disorders. The discussion of HIV focuses on cognitive impairment, a problem that, as the authors report, develops in more than half of people with AIDS.

The Alcohol and Drug Wildcard is driven by

the strong belief that addictions must often be dealt with first to treat other conditions. While the authors of the book do recognize the problems of motivating clients to stop substance use, they are very much informed by a U.S. perspective: they give strong emphasis to abstinence and are too narrowly focused on the option of 12-step approaches and the confrontation paradigm of the disease model. Worse, they fail to consider the many self-help and mutual aid advocacy groups that support people with HIV and with mental health problems. This oversight illustrates one of the disadvantages in putting the addictions wildcard on the table without giving fuller consideration to the other cards in their hand.

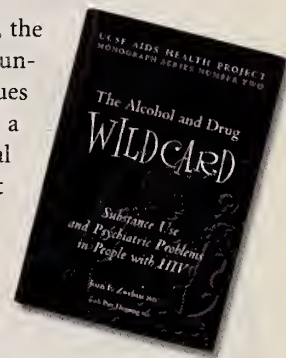
However, Zweben and Denning do make a promising and thoughtful attempt to bring into the dialogue the client-centered pragmatism that is the basis of harm reduction perspectives. (Indeed, if harm reduction and moderation management is to be emphasized for any particular groups, it is for clients with chronic mental health problems and IV drug users, who account for 25 per cent of all AIDS cases.)

Those comments aside, there is much that I valued and appreciated in this book. In less

than a hundred pages, the authors display their understanding of key issues in the same way that a skilled artist can reveal more with a few deft strokes of a sketch than others can do in a detailed, busy canvas. They inform the book with a humane wisdom that is at once practical and integrative: to let the circumstances of each person and situation influence the strategies you use. For professionals or lay persons who find themselves with triple-diagnosed clients, particularly when substance use issues predominate, *The Alcohol and Drug Wildcard* is a useful primer.

WAYNE SKINNER is Clinical Director, Concurrent Disorders Program at the Centre for Addiction and Mental Health.

The Alcohol and Drug Wildcard: Substance Use and Psychiatric Problems in People with HIV, Joan E. Zweben & Patt Denning, UCSF AIDS Health Project Monograph Series, Number Two, University of California, San Francisco, 1998, 98 pp., \$9.95 US.



What twins tell us about ourselves

FINALLY — A BOOK THAT PAYS TRIBUTE not only to the contribution that identical twins have made to science, but to the contribution of fraternal twins as well. In *Entwined Lives: Twins and What They Tell Us About Human Behavior*, Dr. Nancy Segal uses her own experience as a developmental psychologist and fraternal twin (a fact that intrigued me, as I am also a fraternal twin) to fuel her 20-year commitment to the topic of twin research.

In this book, Dr. Segal, currently the director of the Twin Studies Center at California State University in Fullerton, writes for a large audience, not only twins and twins specialists, but anyone interested in human behaviour and what twins studies tell us about ourselves.

Dr. Segal shows us the fascinating interplay of genetics and the environment, and the degree to which they influence a wide range of traits in all humans — everything from athletic ability to personality, TV-watching and even age of first sexual intercourse. Insights range from quirky trivia to more elaborate reflections

on the nature-nurture debate.

Did you know that fraternal twins can be born from different fathers, or that it's possible for twins to be born months apart? Or what about the fact that the rate of fraternal twins varies dramatically in different regions? Among the Yorubi tribe in Nigeria, one in 11 people are part of a fraternal pair, while the rate is as low as one in 330 among Asian populations.

With its strong focus on research, Dr. Segal's book could be criticized as being overly dense and academic, if it were not for her delightfully personal descriptions of twins she has met over the years. We read about twins who are physically joined and resist the chance to be separated, twins among the animal kingdom, twins reared apart, twins adopted together, and famous Canadian twins Bernard and Harold Shapiro, the only known twins to both become leaders of prestigious universities — McGill and Princeton Universities, respectively.

Given the fact that multiple birth rates are rising (due both to increased use of fertility

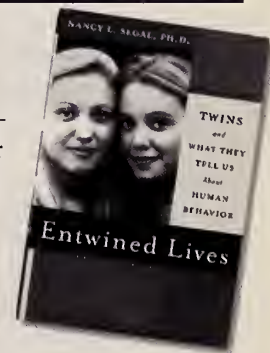
drugs and women delaying childbirth until later in life), the topic of twins is now a personal issue for a much larger segment of the population.

The other day, I had a rare experience — a brief but intimate conversation with several other strangers on a hospital elevator. The conversation began when one woman commented on a couple's twin pram, then another said that her husband was a twin, and still another said that she herself was a twin. And all wanted to know which one each was — fraternal or identical?

This is the kind of curiosity that will no doubt spur interest in Dr. Segal's book.

DIANA BALLON

Entwined Lives: Twins and What They Tell Us about Human Behavior, Nancy L. Segal, PhD, Dutton, New York, 1999, 396 pp., \$39.99.



The Last Word

We welcome submissions from our readers for opinion pieces. For information, contact: The Editor
Journal of Addiction and Mental Health
33 Russell St., Toronto, Ontario M5S 2S1
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Would mandatory addictions treatment work for people on welfare?

BY CHRIS HIGGINS

DURING THEIR WINNING CAMPAIGN IN THE ONTARIO provincial election in June, the Conservatives promised that, if re-elected, they would require welfare recipients to be tested and, if necessary, treated for drug addiction. If such a policy were put in place, the government could force people on welfare who test positive to get addiction treatment.

The stated goal is to render welfare recipients employable, so they can get a job, leave the public rolls and thereby reduce welfare costs. Such testing and treatment is not for medical purposes, but for economic reasons. Failure to comply would result in people losing their welfare income, potentially rendering them destitute and homeless.

Canadian law and constitution generally operate on the premise that people's "expressed interest" takes precedence over their "best interest", as defined by government. Currently, all citizens enjoy the same rights under this law, regardless of their income source. The rights to self determination and consent to treatment can only be bypassed if citizens demonstrate a risk of harm to themselves or others. Does unemployment constitute sufficient risk of harm to compel people into treatment against their will?

The primary reason for continued unemployment amongst welfare recipients is not substance abuse. Most people on welfare do not even have a substance abuse or addiction problem. Job opportunities depend on the job market, education, training and the work experience of the individual.

There are many other practical questions as well. Would mandatory testing and treatment work? Would these initiatives cost more than they save? What are the implications for the current substance abuse and addiction system? Would other approaches cost less and work better? And how would welfare workers identify people to be tested in a fair and unbiased way?

Most drug testing of unwilling people is not reliable. More reliable measures are also more expensive, requiring more complex lab testing and more staff time to administer. Casual alcohol and drug use, which has no effect on employability, will be detected along with serious substance abuse and addiction problems that may affect employability.

People need to be motivated to stop using (alcohol and/or drugs) for treatment to be effective. Typically, the first step in dealing with an addiction or substance abuse problem is accepting that there is a problem and sincerely wanting to make a change. Forcing people to attend programs compromises their dignity and will not bring about the desired change.

Once people have been treated, how will the government know that the treatment has worked, except by more testing and more intrusive

and expensive "policing" by welfare workers? For people to sustain the benefits of treatment, the root causes of the alcohol/substance abuse need to be addressed. Unremedied, these causes will undermine people's gains, increasing the chance of their returning to old habits.

Existing substance abuse and addiction services are overloaded now. Without additional services, the system will simply become more backlogged. But the government has not committed the resources necessary to accommodate more people in the system.

And what of the impact on the treatment programs themselves? People who voluntarily seek help will be competing for services with people forced into the system. The motivated client will share services with the reluctant, resentful or even resistant client. Health care staff's role as helpers and therapeutic allies will become complicated by their role as wardens for unwilling clients.

Given the issues of testing unreliability, less effective treatment and vulnerability to relapse, this approach is likely to be unproductive. Few people will successfully leave behind their addiction or substance abuse habits. Fewer still will find work.

The cost of testing, the cost of building more service capacity and the cost of services delivered in a way that ensures poor outcomes will mean that this approach is unlikely to save any money.

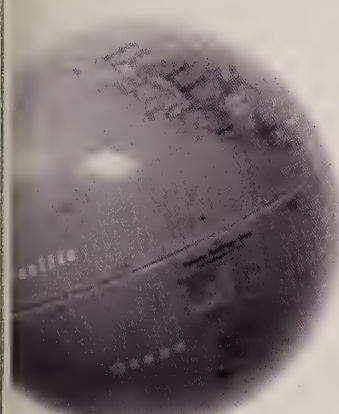
Laws that differentiate people by their wealth or income source create frightening precedents. The cost to the dignity and self-respect of people on welfare will be considerable. For those who are forced off welfare into homelessness, the human cost will be immeasurable. And in the end, the cost to our society will be greater than any benefits that may accrue.

If we are committed to helping people on welfare return to work and if we wish to address the obstacles that substance abuse and addiction problems create, we must commit the funding needed to focused education, outreach and voluntary programs that are accessible and non-stigmatizing. These programs will not involve costly ineffective testing, they will have better outcomes, will build people's self respect and confidence — surely making them more employable — and will spend health care dollars more effectively.

Personal well-being is not something that can be forced on people. It must be sought and worked for with authentic and determined motivation. Substance abuse and addiction services that engage and support motivated people are the only way to create well-being and help people return to work as full members in their community. ■

Chris Higgins is executive director of the Ontario Federation of Community Mental Health and Addiction Programs in Toronto.

Conferences



e-mail <nadd@ulster.net>,
web <www.thenadd.org>.

First Annual Addiction Studies Conference

June 4-7, 2000, London, Ontario.
Contact: 1-800-965-3307 or
(519) 624-8855.

7th Congress World Association for Infant Mental Health

July 26-30, 2000, Montréal, Quebec.
Contact: WAIMH Secretariat,
550 Sherbrooke Street West,
West Tower, Suite 490, Montréal, QC
H3A 1B9,
tel (514) 398-3770,
fax (514) 398-4854,
e-mail <waimh@ums1.lan.mcgill.ca>,
web <www.mcgill.ca/mco/waimh>.

UNITED STATES

National Summit: The National Mental Health Consumers' Self-Help Clearinghouse
August 25-29, Portland, Oregon.
Contact: 1211 Chestnut St.,
Suite 1000, Philadelphia, PA 19107,
tel (800) 553-4539 or (215) 751-1810,
TTY (215) 751-9655,
fax (215) 636-6310,
e-mail <info@mhsselfhelp.org>,
web <www.mhsselfhelp.org>.

Substance Abuse Treatment Protocols for People with Disabilities "Reality & Resources"
September 16, Madison, Wisconsin.
Contact: Bob Oslo, 2411 Park Rd.,
Mosinee WI 54455-8490,
tel (800) 359-5826,
fax (715) 241-7182,
e-mail <wadda@juno.com>.

1999 Great Lakes Conference on Addictions and Mental Health
September 26-29, Indianapolis, Indiana. Contact: Dennis Miller,
P.O. Box 30380, Indianapolis, IN
46230-0380,
tel (317) 283-8315,
fax (317) 283-1038,
e-mail <gr8lakestr@aol.com>.

Canadian Academy of Child Psychiatry / American Academy of Child and Adolescent Psychiatry
October 19-24, Chicago, Illinois.
Contact: AACAP, Meetings Dept., 3615
Wisconsin Avenue NW, Washington,
DC 20016-3007.

National Education Association for Homeless Children and Youth Conference
November 6-9, Orlando, Florida.
Contact: National Education Association for Homeless Children and Youth,
tel (805) 599-8483.

ABROAD

11th World Congress of Psychiatry
Aug 6-11, Hamburg, Germany.
Contact: XI World Congress of Psychiatry,
CPO Hanser Service, Hanser & Co.
GmbH, Office Hamburg, PO Box 1221,
D-22882 Barsbüttel, Germany,
tel 49 40 670 8820,
fax 49 40 670 3283,
e-mail <cpo@wpa-hamburg.de>.

Cont'd...

CANADA

8th Annual David Berman Memorial Dual Disorder Conference

October 14-15, Vancouver, British Columbia.
Contact: Dual Diagnosis Program,
Attention: Laurel Lafant,
1-520 Powell Street,
Vancouver, BC V6A 1G9,
tel (604) 255-9843,
fax (604) 251-4579.

International Association of Psychosocial Rehabilitation Services, Ontario Chapter, 5th Bi-Annual Conference
October 20-22, Niagara Falls, Ontario.
Contact: Sheila Bistro,
tel (905) 641-5222.

INPUT: The 13th Canadian Biennial Symposium on Employee & Family Assistance Programs in the Workplace
November 7-10, Ottawa, Ontario.
Contact: Frank Fallon,
tel (416) 675-6622 ext. 447,
fax (416) 675-0135,
e-mail <fallon@admin.humber.on.ca>,
web <www.humber.on.ca/~input>.

National Association of Dual Diagnosis Conference (developmental disability and mental health needs)
November 10-13, Niagara Falls, Ontario. Contact: Susan Morris,
tel (914) 331-4336,





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Thamesville, Ontario N0P 2K0
e-mail: homeoffice@westover-fdn.org

Conferences

XIII Brazilian Congress on Alcoholism and Other Dependencies

August 11–15, Rio de Janeiro, Brazil.
Contact: Claudia Antonaccio,
tel 55 21 553 6628,
fax 55 21 551 4012,
e-mail <jcdias@spacenet.com.br>,
web <www.abcadrio99.com.br>.

38th International Congress on Alcohol and Drug Dependence

August 16–20, Vienna, Austria.
Contact: Fiona Fretz-Tongue, Project
Co-ordinator, International Council on
Alcohol and Addictions, Case Postale
189, 1001 Lausanne, Switzerland,
tel 41 21 320 98 65,
fax 41 21 320 98 17,
e-mail <icaa@pingnet.ch>,
web <www.icaa.ch>.

European Symposium on Community Action to Prevent Alcohol Problems – European Network on Local Alcohol Prevention, Research and Evaluation

November 18–20, Porto, Portugal.
Contact: Symposium Secretariat, Centro
Regional de Alcoologia do Porto,

Rua Professor Álvaro Rodrigues,
4100-040 Porto, Portugal. Call for
papers deadline, June 15,
tel +351 2 610 01 82,
fax +351 2 610 25 92,
e-mail <alcohol@mail.telepac.pt>.

Psychology After the Year 2000

June 14–24, 2000, University of Haifa,
Israel. Contact: Azy Barak,
tel +972 4 824 9374,

fax +972 4 824 9353,
e-mail <azy@construct.haifa.ac.il>,
web <http://construct.haifa.ac.il/~azy/couninet.htm> or
<http://welcome.to/azy>.

XXVII International Congress of Psychology

July 23–28, 2000, Stockholm, Sweden.
Contact: Stockholm Convention
Bureau, Box 6911, S-102 39

Stockholm, Sweden,
fax 46 8 34 84 41,
e-mail <icp2000@stocon.se>.

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1999
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youth:
reducing risk
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Cover

Rick Franken

hong kong surprise

acrylic on masonite, 12" x 8"



This image of a dragon is about strength, "about a good, right kind of
feeling," says artist Rick Franken. "If I can do it, anyone can."

Franken is a 38-year-old Torontonian who suffers from schizophrenia.
hong kong surprise is part of the 1999 calendar for the Creative Works
Studio, a community art and economic development program in Toronto,
targeted for a diverse inner city population. For more information
about the program, call (416) 864-5972 or e-mail <create@total.net>.

News from the Centre

As the next step in Strategic Planning, we have established strategies for program planning in the Centre's Clinical Programs and Community Health and Education Programs, and for implementing the recently approved eight Strategic Directions. Implementation Teams are developing workplans that will guide the Centre in realizing the Strategic Directions. Their work is expected to be completed in early 2000.

On another front, the Centre has undertaken a project to develop, implement and evaluate models of co-ordinating mental health and addiction programs. This is in response to research indicating that people in treatment for either an addiction or mental health problem have higher rates of concurrent disorders than the greater population and the fact that assessment and treatment services have been inadequate for this population. In a 1996 Ontario needs assessment called "Travelling the Same Road: A Report on Concurrent Disorders in Ontario," service providers at addiction and mental health agencies identified the need for increased co-ordination among programs as a strategy for improving services for individuals with concurrent disorders.

For the Centre's project, two communities will each develop a model of co-ordination tailored to the needs of their regions. The project will examine the agency characteristics associated with greater or lesser degrees of co-ordination; the co-ordinating structures in place both before and after implementation of the model; how concurrent disorders are identified and treated before and after model implementation; and the impact of a "system-defined" co-ordination model on service provision. Results of this research should enable the Centre to inform other Ontario communities about collaborative models that could enhance service to people presenting with both a mental health and addiction problem.

In other news, the Centre has spent the summer months planning the integration of its Toronto sites, as one of the directives regarding the Centre's merger issued by the Health Services Restructuring Commission. A final decision regarding the location of staff and programs will be made in the fall. In addition to increasing efficiency and eliminating duplication, site consolidation will allow the Centre to increase the quality of services while decreasing the costs of delivering these services in improved space with state-of-the-art technology. The site integration will take three to five years to redevelop and will not affect the Centre's regional and satellite offices.

Finally, the Centre's first Annual General Meeting was held on September 16th and the 1998-99 *Annual Report* will be distributed shortly. To add your name to the mailing list, call Public Affairs at (416) 595-6878 or e-mail <chendry@arf.org>.

BY RENA SCHEFFER

Editor's message

This issue marks one year in the life of *The Journal of Addiction and Mental Health*. The structure of *The Journal* has already been created — with its covers designed by consumer artists, its combination of news and features covering the latest developments in the addiction and mental health fields, and its rotating guest editorial (Last Word) and Focus section — this issue on youth.

Over the next several issues, I hope to expand the range of topics and perspectives to reflect a wider readership, not only within Ontario but across Canada and internationally. You can also expect that the inside pages of the magazine will include more of the inspiring artwork of consumers, as well as a cross-section of photography and other artwork from Canadian artists.

This issue, we were lucky enough to have the contribution of Toronto photographer Nir Bareket, who over the course of a year, took photos of Toronto's homeless — in shelters, on the street and in doorways (see pg. 9). And we have several photos and poems by the teenagers of L.O.V.E. (Leave Out ViolencE) — the product of a photojournalism program in which youth document issues of violence through pictures and words. As Kalyani Vittala's story describes, what better way to reflect the concerns of today's youth than encouraging teenagers to offer their own insights to issues affecting them.

Other stories cover a range of topics: a large North American study will treat people as young as 12 exhibiting "early" signs of schizophrenia in the hopes of preventing the illness from ever occurring; a new approach to treating people diagnosed with borderline personality disorder offers a more hopeful prognosis for people suffering from this previously difficult-to-treat condition; and "animal hoarding" — experts in Massachussetts have created a consortium to identify characteristics of hoarders, and how the phenomenon may be linked to certain mental health problems.

I'm lucky to be joining a great team: a professional group of freelance writers, a volunteer editorial advisory board made up of addiction and mental health experts, and the support of hardworking writers and designers here at the Centre for Addiction and Mental Health.

Now it's your turn. Tell us how we're doing and what we could do better. Write a "letter to the editor." Give us a phone call. We want to ensure that this publication reflects your interests.

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Downloaded

"Nearly half of the U.S. teens and children who entered treatment in 1996 were admitted for abuse or addiction to marijuana alone."

This is one of the highlights of the report released this past summer by the National Center on Addiction and Substance Abuse (CASA) at Columbia University. **Non-medical Marijuana – Rite of Passage or Russian Roulette?** is generating a lot of discussion about how changes in the legal status of marijuana could affect children and adolescents' attitudes and beliefs about cannabis. Visit the

CASA site <www.casacolumbia.org> to read the news release (see **Newsroom**) or to download or order this lengthy report.

The Mayo Clinic Health Oasis found at the Mayo Clinic web site <www.mayo.edu> offers reliable, timely health information for the general public on a variety of topics, including mental health. A search on this topic pulled up a range of informative readings and answers to such queries as:

Can St. John's Wort relieve depression?
Is there a link between food and depression?

Can the Internet reduce social phobia?

SHEILA LACROIX

In Brief



Animal hoarders need help, experts say

Though not yet recognized as a syndrome or disorder, people who hoard large numbers of cats and dogs may well suffer from some kind of psychological disorder, according to Gary Patronek of the Center for Animals and Public Policy at Tufts University School of Veterinary Medicine in Massachusetts. He estimates that this largely hidden problem results in at least 2,000 cases in the U.S. each year. The typical profile of a hoarder, according to a study by Patronek, is a woman in her 60s, living alone, who has collected enough pets to the point that she is severely neglecting them — and possibly not even recognizing that the animals are dying or getting sick as a result. A Hoarding of Animals Consortium has been developed in Massachusetts to study the phenomenon of animal hoarding and its relationship to such mental health problems as obsessive-compulsive disorder.

Retailers sell cigarettes to children

A Health Canada study released in June found that 39 per cent of tobacco retailers in Canada were willing to illegally sell cigarettes to minors. Testing 5,023 retailers in 26 cities between July and September 1998, the study revealed a six per cent increase over the previous year in tobacco sales to adolescents. New Brunswick was purported to be the province least compliant with the law, while Newfoundland was reported to be the most compliant.

Spirited sales

According to a recent Statistics Canada study, for the first time in more than a decade, Canadians purchased more distilled spirits in 1997-98 than they had the previous year. While the increase in liquor sales is attributed to spirit-based coolers, beer still retains the lion's share of the alcohol-buying dollar. However, overall,

Canadians are still buying much less wine, beer and liquor than they ever have before.

Heads I win, tails you lose

During its first year of operation, the Ontario Problem Gambling Helpline recorded 4,224 calls from gamblers seeking help for their addiction. Already averaging 400 calls a month, inquiries to the helpline are expected to increase as word of its existence spreads throughout the province. Gambling addiction is considered by the Canadian Psychiatric Association to be the fastest growing psychiatric disorder in Canada. According to several recent North American studies, one to four per cent of the adult population has a gambling problem.

That's no joke

At a conference on humour studies, University of Western Ontario psychologist Rod Martin challenged beliefs about the direct therapeutic effects of laughter. Despite anecdotal evidence about the healthful benefits and consequences of humour, Martin is sceptical of such claims, and questions whether humour can, for example, help fight cancer or prolong life. Martin cautioned that over-blown claims about healthful side-effects of laughter could discredit the field of humour studies.

Smoke and mirrors

In July, a Florida jury ruled that cigarettes are addictive, that they cause lung cancer and that these facts were purposefully hidden from the American public by the U.S. tobacco industry. This billion-dollar class action lawsuit against the tobacco industry is the first ever to be successful.

Pot testing comes to the NBA

As training camps open this October, all National Basketball Association players will be tested for marijuana use. This marks the addition of marijuana, along with steroids, to the league's banned substances list. Rookies will be tested for marijuana four times a season, on a random basis, while veterans will be tested if an arbitrator decides that there is good cause to suspect its use, possession or distribution. If detected at training camp, players must undergo counselling, while subsequent detections will bring fines and suspension.

Nothing ecstatic about ecstasy

According to research findings published in the June 15 issue of *The Journal of Neuroscience*, use of "ecstasy" (or MDMA) has been shown to cause long-lasting damage to brain areas critical for thought and memory. An experiment using red squirrels indicated that four days of ecstasy use could cause damage lasting for six to seven years. With these findings, researchers at Johns Hopkins University were able to validate previous research on humans indicating that ecstasy's use resulted in low scores on memory tests. Ecstasy damages nerve cells that use the chemical serotonin to communicate with other neurons in areas of the brain where conscious thought occurs.

Exercise may alleviate depression

A recent review of psychological research, published in the June issue of *Professional Psychology: Research and Practice*, indicated that exercise is an effective but underused treatment for mild and moderate depression. Examining studies that date back to 1981, researchers concluded that exercise is a viable and cost-effective treatment option for people with a variety of psychiatric disorders. Evidence suggests that its use may also be helpful in treating schizophrenia, alcohol dependence, body image problems and some anxiety disorders.

Hearing loss distressing in elderly

A recent study by the U.S. National Council on the Aging (NCOA) revealed that untreated hearing loss can cause anxiety and lead to a decrease in social activity among the elderly. Though nine million Americans over the age of 65 are affected by hearing loss, roughly 60 per cent of them are unwilling to use hearing aids, out of embarrassment and denial. The social isolation that this can engender may lead to feelings of sadness, emotional distress and depression. More information regarding the study, which examined 2,300 hearing impaired adults, may be acquired by visiting the NCOA Web site at <www.ncoa.org>.



Drug may one day help reduce cravings to cocaine

ONE TRUCK DRIVER CONNECTED HIS cocaine use so much with driving a truck that even after a year of no driving or drug use, he was smoking crack within an hour of driving again.

This is the challenge for people quitting a cocaine habit — dealing with the cravings that arise if they come into contact with their drug-taking environment.

But a new drug may one day help people overcome their cocaine addiction by targeting how the body deals with these triggers. Results from a new study show that the drug BP 897 reduced the impact of environmental cues that triggered rats (with a history of self-administering cocaine) to seek out the drug.

People addicted to cocaine and other drugs can be spurred to use by seeing places linked to their drug interactions, by people associated with their drug use or by images of drug paraphernalia, even after they are abstinent.

“In humans we know these stimuli can induce cravings,” said Barry Everitt, co-author of the article discussing this issue, which was

published in the July 22 issue of *Nature*. “That’s what often fuels relapse to the addiction cycle,” said Everitt, who is also professor of behavioural neuroscience at the University of Cambridge in the U.K.

In the study, rats were first trained to press a lever to get cocaine. Each time they did this a light went on, until the light became the rats’ environmental cue associated with their drug use.

Later in the study, the rats were no longer given the cocaine. Still, they continued to push the lever for long periods when the light was on, showing that they had been conditioned to seek cocaine based on the presence of light.

Some rats were then injected with the drug BP 897. Now when the light went on, these rats only pressed the lever half as often as rats injected with saline in the control group. After 15 minutes, all rats were given access to cocaine and there was no difference in the drug-seeking behaviour between the two groups.

If BP 897 has the same effect on humans, these results suggest it could reduce their conditioned cravings and drug-seeking responses, according

to Drs. Gary Ashton-Jones and Jonathan Druhan of the University of Pennsylvania’s Department of Psychiatry, who co-authored a commentary accompanying the article.

Another advantage of BP 897 is that it does not appear to be addictive, making it unlikely to become a drug of abuse itself. Nor does it induce the rats to increase cocaine doses when they do have access to the drug. Other cocaine medications that block cocaine’s effect may prompt users to take larger doses, said Everitt.

Clinical trials with BP 897 on humans could begin within the next two years, he said.

BP 897 was created by French researchers specifically to target D3 dopamine receptors, which have been implicated in addiction. These receptors are stimulated by dopamine, a brain chemical whose levels increase after cocaine is taken.

“[The researchers’] approach should stimulate the development of a new generation of pharmacotherapies for cocaine addiction,” predict Drs. Ashton-Jones and Druhan.

ANITA DUBEY

Results of group CBT study show promise

GROUP COGNITIVE-BEHAVIOURAL Therapy (CBT) is an effective treatment for people with a co-existing anxiety disorder and substance abuse problem, according to a recent study. Given that almost 25 per cent of subjects suffering from an anxiety disorder also have one or more substance abuse disorders, this finding could have a significant impact on a large number of sufferers.

The study — done in partnership between the Regional Niagara Public Health’s Community Mental Health Program (CMHP) and the Niagara Alcohol and Drug Assessment Services — involved a 10-week program, in which patients received CBT but no medication. CBT, a therapy used to treat many psychological disorders, is based on the premise that thoughts and feelings are inextricably linked. The therapy teaches clients to understand, challenge and thus control their negative thinking.

A total of 93 patients completed the study. Patients’ perceived level of anxiety and their

ability to cope with anxiety without the use of substances was measured through questionnaires at the first and 10th sessions, and six months and one year following the program. The study indicated that group CBT was effective in reducing patients’ perceived intensity of anxiety, and in increasing patients’ ability to face the anxiety attacks without the use or misuse of substances up to one year later.

This is an encouraging result as group therapy is not only effective — enabling participants to benefit from each other’s experiences — but also a cost-efficient alternative to individual treatment. Dr. Neil Rector, head of the Anxiety Disorders Clinic at the Centre for Addiction and Mental Health adds that “Seventy-five to 90 per cent of people treated with CBT for anxiety disorders get significantly better.”

However group therapy may not always be beneficial for very disturbed patients, according to an earlier American study. In fact, this new Niagara study also found a correlation between the severity of patients’ perceived level

of anxiety and those who drop out of the program. CMHP program therapist Rick Crysler recognizes this barrier and works individually with people who indicate a discomfort with attending groups, until they are ready to participate with the others.

Crysler’s experience has shown that people with these co-existing problems are a very easy group to treat, because they are highly motivated to get better. They have experienced anxiety and want to learn how to manage it, he adds. Dr. Rector agrees, remarking that many patients do benefit from this treatment, which is likely to be effective only if the patient is highly motivated to actively work on developing effective coping skills.

Historically, if someone with a co-existing anxiety disorder and substance abuse problem sought treatment, the clinician would determine which disorder was more prevalent and would only treat one of the two conditions. This study provides hope that both problems can be dealt with together in a timely and effective way. CHRISTA HAANSTRA

Heat and meds: a dangerous mix

AS THE MERCURY SOARS, EVERYONE LOOKS FOR WAYS TO beat the heat. For people on antipsychotic or anti-Parkinsonian medications, escaping the heat is crucial — as it can result in heat-related illnesses — a risk that is of particular concern for the homeless.

Neuroleptics, such as chlorpromazine and thioridazine, and anti-parkinsonian and anti-cholinergic drugs, such as benztropine, deprive the body of certain mechanisms that protect people from the heat, says Dr. Ty Turner, Chief of Psychiatry at St. Joseph's Health Centre in Toronto. With these protective mechanisms hampered by the medication, or medication prescribed to counteract the original medication's side-effects, it is difficult for the body to sweat or release heat, which can then culminate in hyperthermia or heat stroke, Dr. Turner says.

For people taking medication and living in poorly ventilated apartments or institutions without air-conditioning, a lack of water or protection from the heat can cause the body temperature to rise to dangerous levels. Homeless people are most at risk because they have no control over their environment, and spend much of their time outdoors, Dr. Turner says. The hot and humid weather has called for aggressive interventions, says Cynthia Karlton, co-ordinator of a program that provides medical

and psychiatric services in shelters. Run jointly by the Centre for Addiction and Mental Health and Toronto Western Hospital, workers distribute sun block, hats, socks and water to clients over the summer.

"We see people who are very vulnerable when it comes to the weather," she says, noting that homelessness perpetuates medical problems. Add dehydration, swelling and blistered feet, exhaustion, sunburn and a host of other heat-related illnesses, and life on the streets becomes an especially serious health risk in the summer.

For Krysia Tomsic, a nurse at the Fred Victor Women's Hostel in Toronto, the key is keeping informed. "Education is really the big thing, just talking to people and letting them know to keep out of the sun and to find someplace cool."

This past summer the Metro Toronto Public Health Department issued fact sheets to organizations that work with people who are homeless or live in sub-standard housing to raise awareness about the issue.

Kathleen Harte, a community manager with the health department, says that "One of the biggest problems is that some people may seem to be intoxicated, when really it [their response] is a reaction to the heat and their medications." **MARK CRANE**

Losing may be the best way to prevent gambling addictions

WHILE MANY DIFFERENCES EXIST between problem and social gamblers, one key difference is, ironically, based on chance.

Problem gamblers tend to have a winning streak or big win early in their gambling careers. "These are the people at greatest risk of a gambling addiction," says Nigel Turner, a scientist at the Centre for Addiction and Mental Health. "They've been conditioned to believe it will pay out."

In a new study conducted by Turner and colleagues, 50 per cent of problem gamblers in

treatment reported early wins, compared to none of the social gamblers, confirming earlier findings.

People who win early on tend to get both positive reinforcement, from the thrill of winning and the financial pay-off, as well as negative reinforcement, as a temporary escape from emotional or other problems.

The study of more than 150 people also found that, although problem gamblers had a slightly worse understanding of odds, in general most people did not have a sense of how randomness worked. Winning therefore reinforces any player's incorrect perceptions, and also feeds into dreams. "Winning enhances their belief they can predict the outcome of chancy events," says Jeffrey Derevensky, an adolescent gambling expert and psychology professor at McGill University in Montreal.

The Centre study also found that problem gamblers were more likely than social or infrequent gamblers to find patterns in a series of lines, whether there was an actual pattern or the lines were randomly drawn and just interpreted as patterns.

The "ability" to find such connections suggests that this might be part of the reason why problem gamblers get hooked, says Turner. But the pattern is an illusion, because each dice roll, slot spin or roulette result is independent of others.

As treatment, correcting these "cognitive biases" has been proven to help. In one of the

first controlled studies on gambling treatment, Robert Ladouceur, a psychology professor at Laval University in Quebec, found that 85 per cent of problem gamblers were abstinent after these biases were corrected.

But gambling venues do their bit to reinforce incorrect perceptions. Casinos may show the last 20 spins of the roulette tables, creating the illusion that gamblers can predict the outcome, says Derevensky.

Other risk factors contribute to problem gambling as well, notes Turner. These include social and emotional problems, and a physiological predisposition among people with impulsivity or attention-deficit/hyperactivity disorder. However, Turner believes that winning alone is sufficient to place someone at risk.

Although correcting biases may work for adults, Derevensky stresses that any prevention or treatment program for adolescents must teach skills that help them learn to cope with adversity.

Various new prevention initiatives are underway. The Centre is developing a program that teaches randomness and coping skills to students from Grades 6 to 12. In Quebec, a video teaching about randomness will be shown to students in Grade 8 and early high school this fall. "We're not saying don't gamble," says Ladouceur. "We're saying there's no way you can impact the outcome."

The best prevention, though, is to have people lose, says Turner. **ANITA DUBEY**



Aboriginal communities participate in policies to reduce harmful drinking

THREE FIRST NATIONS IN ONTARIO ARE TAKING PART IN AN innovative process to reduce alcohol-related harm in their communities. Over a two-year period, these aboriginal communities — in partnership with the Centre for Addiction and Mental Health (CAMH) — will be developing and evaluating community-based policies to target three environments: drinking in the home; alcohol sales through retail outlets such as motels, restaurants and stores; and alcohol use in recreation facilities and at open social gatherings.

“To our knowledge, First Nation communities in Canada have never before developed policies attempting to manage drinking in their communities’ living environments,” says CAMH Program Leader Ron Douglas. “While we do know that five First Nations communities in Ontario have developed policies on managing alcohol, these policies have been confined to drinking in recreation facilities. Our new challenge is to broaden its application to other environments in the community.”

Historically, because of the severity of alcohol-related problems, aboriginal communities have tended to adopt a position of abstinence. In more recent times, however, reserves near non-native communities have begun to abandon prohibitionist policies. A 1993 Statistics Canada survey indicated that more than 60 per cent of 1.5 million adult aboriginals considered alcohol to be a problem in their community. What has been missing, for those who wish to drink, is community consensus on how alcohol will be made available and used, so that people consume in a less damaging manner.

According to Program Consultants Angie Chiu and Claire Narbonne-Fortin, there seems to be a readiness among First Nations to try a new approach. “As we visited various aboriginal communities to explore their

interest in alcohol policy development, people expressed a desire to try new culturally-relevant interventions that would complement existing prevention and health promotion programs in their communities.”

To incorporate community customs and traditions, each community is preparing to involve their members in forming a policy development team whose role will be to propose a policy for community review and Council approval. Community policy teams will be looking at various ways to reduce alcohol use. This might require that some outdoor areas be designated alcohol-free zones and that people serving alcohol in designated wet facilities be oriented to the policy regulations and be trained in responsible serving practices. The policy might also include stipulations requiring drinks to be served in paper cups as opposed to glass to minimize chances of injury; sales within the community to be limited to low-alcohol products; and policy recommendations requiring a contractual agreement be signed between the Band and house owners or renters to address drinking in the home.

Once the policy is devised and accepted, it will likely be promoted through community potlucks or other festivities. The hope, says Evaluator Marg Rylett, is to then offer these policy prototypes to other aboriginal communities for continued application and monitoring.

RENÉ LAUZON

René Lauzon and Judy Desmoulin signing Letter of Agreement at Long Lake, one of the three First Nations involved.



Aboriginal drinking patterns in Canada similar to Australia

Between 60 to 80 per cent of violent crimes by indigenous Australians involve alcohol, with domestic violence accounting for many of these assaults, according to Associate Professor Sherry Siggers, an expert on indigenous Australian health.

Speaking recently at the Centre for Addiction and Mental Health, Siggers said that indigenous women in Australia are 40 times more likely than non-indigenous women to be victims of spousal violence; about one quarter of adult indigenous Australians admitted to hospital are admitted because of alcohol-related problems; and the indigenous population die younger than the general population of the country.

But the situation isn't as bleak as these statistics might imply. To the contrary, she said that research and recommendations for reducing harmful drinking are being facilitated by indigenous people's own actions in regulating the supply and promotion of alcohol in their communities.

Summarizing collaborative research conducted by Edith Cowan University and the National Centre for Research into the Prevention of Drug Abuse at Curtin University of Technology in Australia, Siggers described the investigators' recommendations. These include banning the sale of damaged wine casks; discouraging alcohol discounting; reviewing the role of taxi drivers in the supply and promotion of alcohol to aboriginal people; and restricting or banning alcohol sales at particular times and places.

Siggers also compared aboriginal drinking patterns in her home country to the situation in Canada.

“In Australia, the abstinence model is not nearly so prominent [as in Canada]. I hadn't even heard the word ‘recovery’ until I came to this country,” she said. Most indigenous people in Australia who do give up or reduce drinking do so on their own, rather than through treatment programs as exist in Canada, she said.

But Siggers described similarities as well. In both Canada and Australia, citizenship was granted to indigenous people at about the same time as prohibition was lifted (around the 1960s), which resulted in many indigenous peoples associating the granting of voting rights with drinking rights. And while more aboriginals than non-aboriginals abstain in both countries, those aboriginals that do drink are more likely to do so to excess. For Canada and Australia, this results in the same kinds of social problems; in particular, higher rates of domestic violence, school absenteeism and financial difficulties. **DIANA BALLON**

Sherry Siggers and Dennis Gray are co-authors of *Aboriginal Health and Society: The Traditional and Contemporary Aboriginal Struggle for Better Health* (Allen & Unwin, 1992), \$25 US; and *Dealing with Alcohol: Indigenous Usage in Australia, New Zealand and Canada* (Cambridge University Press, 1998), \$20 US.

Research Update

Alcoholics may misinterpret facial expressions

Alcoholics are more likely to overestimate the emotional intensity of people's facial expressions, as well as misinterpret these expressions (with a bias towards anger and contempt), according to a study in Brussels, Belgium. In the study, investigators compared the response of 25 alcoholics and 25 similarly matched non-alcoholics to facial expressions conveying a variety of different emotions. They concluded that alcoholics' overreactions and misinterpretations may lead to conflicts or problems in their social life. Helping recovering alcoholics to better identify facial expressions might better lead to their re-establishing satisfactory social relations.

Alcoholism: Clinical and Experimental Research, v. 23, no. 6, 1031-1038. Pierre Philippot et al, Department of Psychology, University of Louvain, Belgium.



Heroin overdose – accident or suicidal behaviour?

In a British study of 48 heroin addicts, researchers found that 54 per cent of subjects had overdosed at one point or another, while 35 per cent had attempted suicide. History of suicide attempts and overdose were found to be significantly associated. While those who had attempted suicide seldom did so by overdosing on heroin, researchers concluded that non-intentional overdoses and suicide attempts are potential risk markers for each other. Though overdose is a common cause of premature death among opiate addicts, and substance misuse is known to increase the incidence of completed suicide, little research had been undertaken to examine the connection between non-intentional overdoses and intentional overdoses or suicides.

Journal of Substance Use, v. 4, no. 2, 88-91. Louisa Vingo et al, National Addiction Centre, London, UK.

Frequent moves linked to early drug use

There is a highly significant, positive relationship between the number of geographic moves before age 16 and early use of illicit drugs, according to a Toronto study. Results were based on a sub-sample of young adults aged 18 to 35 obtained from the 1990-1991 *Ontario Mental Health Supplement*. According to the study's author, David J. DeWit, the link between moving and early drug use may not be direct, but rather, mediated by such factors as familial discord, lack of parental supervision and low self-concept. In-school programs aimed at relocated youth are recommended to counteract this relationship, and delay the age of onset of illicit drug use.

Addictive Behaviors, v. 23, no. 5, 623-631. David J. DeWit. Centre for Addiction and Mental Health, Toronto, Ontario.

Financial burden of schizophrenia in Canada staggering

In 1996, schizophrenia cost Canada \$2.35 billion in health care costs and lost productivity. Employing a prevalence-based approach, researchers found that the estimated 221,000 Canadians with schizophrenia exerted a financial burden of \$1.12 billion in direct health care and non-health care costs. Acute care and provincial psychiatric hospitals accounted for almost half of this cost. But by far the largest cost was the \$1.23 billion in lost productivity attributed to the morbidity and premature mortality associated with schizophrenia. Researchers concluded that effective management and control of the disease would result in large cost savings.

Canadian Journal of Psychiatry, v. 44, June 1999, 464-472. R. Goeree et al., Centre for Evaluation of Medicines, St. Joseph's Hospital, Hamilton, Ontario.

Risks of premature death increase

Lifelong smokers are about twice as likely as lifelong never smokers to die prematurely (before age 70), according to researchers. They cited coronary heart disease and cancer as the principle causes of premature death. Investigators determined the probability of dying prematurely by constructing and examining abridged life tables for four hypothetical Canadian cohorts (male and female current smokers, and male and female never-smokers) at age 15. Though a wide range of public interventions have contributed to decreases in the prevalence of tobacco use, this study provides further justification for creating a comprehensive strategy aimed at reducing the onset of tobacco use during adolescence — the time when most begin this highly addictive behaviour.

Chronic Diseases in Canada, v. 20, no. 1, 36-39. Larry F. Ellison et al, Cancer Bureau, Laboratory Centre for Disease Control, Health Canada, Ottawa, Ontario.

Dementia contributes to cause of death more often than expected

Dementia, a disease characterized by confusion, disorientation and intellectual impairment, is known to affect eight per cent of the over-65 population in Canada. Though dementia itself does not seem to be life-threatening, the complications associated with this disease often are. Analyzing multiple-cause-of-death data from more than 113,000 death certificates, researchers at Statistics Canada sought to find causes that are significantly likely and significantly unlikely to combine with dementia to result in death. Data suggested that dementia contributes to death more than twice as often as it is identified as the main cause of death. Treatment for some medical conditions may offer the added benefit of preventing or delaying the onset of dementia.

Chronic Diseases in Canada, v. 20, no. 1, 26-34. Kathryn Wilkins et al, Statistics Canada, Ottawa, Ontario.

Victims of childhood sexual abuse don't necessarily dissociate

Women reporting child sexual abuse exhibit more "immature" coping styles than women who have not experienced this abuse, according to a New Zealand study. Using a random community sample of 354 women, the study found that women reporting the most severe sexual abuse demonstrated the most immature coping styles. These styles involved displacement, passive-aggression, somatization and projection — but not dissociation, as had been hypothesized. The findings suggest that these coping styles may be carried into adulthood, potentially resulting in psychiatric problems and low self-esteem.

American Journal of Psychiatry, 156:7, July 1999, 1080-1085. Sarah E. Romans et al, Department of Psychological Medicine and the Department of Preventive and Social Medicine, Dunedin School of Medicine, University of Otago, Dunedin, New Zealand.



Combining therapies reduces drug use

Combined individual and group drug counselling reduces cocaine use more effectively than group drug counselling alone or in combination with cognitive or supportive-expressive psychotherapy, according to a recent study funded by the National Institute on Drug Abuse (NIDA), National Institutes of Health. The NIDA Collaborative Cocaine Treatment Study was a multi-centre, co-operative clinical trial of several behavioural therapies for treating cocaine. In a randomly selected group of 487 patients receiving a variety of counselling techniques, patients who received both group and individual drug counselling reduced their frequency of drug use the most.

The Archives of General Psychiatry, v. 56, no. 6, 493-502. P. Crits-Christoph et al, University of Pennsylvania, Philadelphia, Pennsylvania.

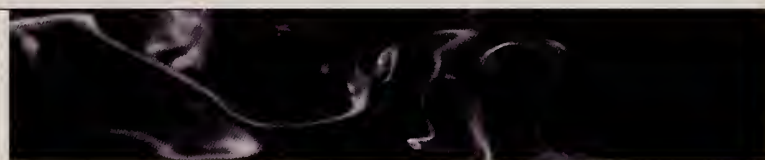
Supervised consumption of methadone introduced to U.K.

Though supervised consumption of methadone at a drug clinic or pharmacy is almost a universal practice, in the U.K., its introduction has been greeted as a surprising innovation. The process was introduced as a means for reducing both the amount of methadone available on the street and the growing problem of fatal overdoses. Interviewing 86 clients participating in the new system about their experiences, researchers found that the introduction of supervised methadone has been positive, helping to reduce the amount of street methadone and ensuring compliance with the prescribed treatment. Further research will need to be conducted to establish the benefits of supervised consumption for methadone maintenance treatment in the U.K.

Journal of Substance Use, v. 4, no. 2, 92-97. Selina Lovell et al, National Addiction Centre (Institute of Psychiatry/Maudsley Hospital), London, U.K.

Asthma drug can improve lung functioning in smokers with COPD

Daily use of corticosteroid budesonide (Pulmicort), a drug inhaled in the treatment of asthma, can result in a significant, rapid and lasting improvement in the lung functioning of those with a mild to moderate case of chronic obstructive pulmonary disease (COPD), according to a recently published study by the European Respiratory Society. COPD is a disease that causes such symptoms as chronic bronchitis, emphysema and small airway disease from cigarette smoking. The disease affects 750,000 Canadians and is the fifth most common cause of death in



Canada. Though quitting smoking should be paramount for anyone suffering from this disease, this study — a double blind, placebo-controlled trial involving more than 1,000 participants — indicates that budesonide will allow those affected to lead more active and better quality lives.

The New England Journal of Medicine, 1999; 340 (25) 1948-1953. R. Pauwels et al, European Respiratory Society, Lausanne, Switzerland.

CHRIS HENDRY



Dialectical Behaviour Therapy

Treating the dramatic symptoms of
borderline personality disorder

BY TAMSEN TILLSON

IN THE FIRST MONTH THAT SHE BEGAN treatment, Michelle* overdosed and slashed her arms repeatedly, landing her in hospital a dozen times. But she didn't die. In fact, she never wanted to die.

While some people with borderline personality disorder such as Michelle are suicidal, suicide was not Michelle's intent, explains Dr. Shelly McMain, supervisor of the Centre for Addiction and Mental Health program where Michelle is treated. These types of self-harming acts, carried out without the person actually wanting to commit suicide, are what are termed "parasuicidal tendencies," and they're not unusual for people with the disorder. They were Michelle's way of communicating painful emotions, McMain says.

For years, there was no one established treatment for people with borderline personality disorder. Then in the early 1990s, Dr. Marsha Linehan, a professor of psychiatry and psychology at the University of Washington, brought hope. She introduced a new treatment regime called Dialectical Behaviour Therapy (DBT). In 1991 the groundbreaking results of a study headed by Linehan were published — in which researchers found that the condition of 47 severely dysfunctional, chronically parasuicidal women with borderline personality disorder improved significantly when undergoing DBT.

"DBT is the first approach that has really given people a sense of hope or optimism," says McMain. "Compared to treatment as usual, DBT has been shown to help reduce parasuicidal behaviour and substance abuse, and to decrease these individuals' reliance on the health care system."

Without understanding the impact of the disorder on people's lives, it's difficult to realize the significance of such a discovery. Those afflicted with the disorder — 75 per cent of whom are women — are impulsive, highly sensitive emotionally and prone to sudden and dramatic shifts in their mood. Therapists can expect to be worshipped one minute and vilified the next. They can expect frightening and

dangerous behaviours that are extremely difficult to change — and for the disorder to be accompanied by other conditions such as eating disorders, addictions or mood disorders. They can also expect clients to miss appointments, or drop out, thereby compromising their treatment.

But with DBT, both clients and therapists have reason for optimism. DBT combines cognitive and behavioural therapy strategies by blending Western psychology and Eastern Zen practice in what Dr. Linehan terms "the reconciliation of opposites." "The most fundamental dialectic is the necessity of accepting patients just as they are within a context of trying to teach them to change," Dr. Linehan writes in *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (1993). "DBT blends a matter-of-fact, somewhat irreverent and at times outrageous attitude about current and previous parasuicidal and other dysfunctional behaviours with therapist warmth, flexibility, responsiveness to the patient and strategic self-disclosure."

It sounds like an oxymoron. But the key is to validate and also to challenge the client, says Isabelle Niquette, a psychologist at the Community Mental Health Centre in Moncton, N.B. If a client says she's quitting therapy, instead of trying to convince her to stay, for example, the therapist might ask if she'd like a referral.

Clients participating in DBT programs make use of a combination of therapies. They attend skills training meetings with about six or eight other clients for two hours a week. They keep a diary card, receive individual therapy — usually once a week for 60- to 90-minute sessions — and have access to telephone consultations with the therapist.

Niquette describes the behavioural analysis component of DBT. "It assesses minute by minute, second by second, the [problematic] event. We don't necessarily focus on what they did so much as what led up to that, so we have to look at what went on, and we go into excruciating detail. Usually it's really painful for clients... at first, but after a while they get used

to the type of questions we ask them, and they get to the answers — the thoughts, emotions, body memories, reactions of others — looking at what is reinforcing the parasuicidal behaviour."

DBT is particularly innovative in that it also incorporates support for therapists, skills trainers and group facilitators as an integral component of treatment. (In fact, in Washington, DBT is covered by third party insurance only as long as the clinician support component is included, says McMain.)

DBT is a slow, difficult process — often taking more than a year before clients abandon their dangerous high-risk behaviour.

"Many of the clients I work with don't feel justified in asking for help unless their arms are dripping with blood," says McMain. But it does help. Michelle hasn't overdosed or cut herself in more than four months. And she recently went back to work. ■

*not her real name

DBT makes its way to Canada...

While DBT spread like wildfire through the States, it's only recently been introduced in Canada, where there are still only a handful of programs.

The first was established in 1995 at the Community Mental Health Centre in Moncton, N.B., with three therapists, two psychologists and a nurse for 12 clients.

Another was developed at the CAMH, where McMain works. Her program — as far as she knows — is the only one to specifically target clients with both a diagnosis of borderline personality disorder and a substance abuse problem. Like the Moncton program, the ratio of staff to clients is high.

The reason for the paucity of Canadian programs is that therapists learning to practice DBT often have to go to the United States for training. However Corrections Canada is carrying out some DBT training, and the CAMH will be launching its own introductory and advanced DBT training courses in the early new year.

Face of homelessness is poor, vulnerable and female

BY CINDY MCGLYNN

SADLY, "HOMELESSNESS" IS A WORD that most Canadians are familiar with these days. Media reports cover the phenomenon, politicians debate solutions, academics study societal causes and activists say it should be called a catastrophe. People are aware that something is wrong.

What people may not know is that today, homelessness has a face. And increasingly, according to sociologist Diane Meaghan, that face is "poor, vulnerable and female."

"Women become the fastest growing segment of the homeless, because of the fact that single mothers with children are the fastest growing sub-population of homelessness," Meaghan said in a recent phone interview.

Working with photographer Nir Bareket, Meaghan has prepared an innovative study of this female face of homelessness. Her academic paper, entitled "About Face: The Social Construction of Homelessness Among Women In Toronto the Good," was originally presented to the Canadian Sociology and Anthropology Association this past summer.

Her study argues that a complex interplay of political and economic factors — and not individual weaknesses — is responsible for homelessness.

Meaghan says her own motivation for the work came in part from observing the startling growth in the number of women on the streets in Canada. Her paper spells out alarming statistics but is especially remarkable for its portrayal of the women themselves.

She interviewed 35 Toronto women of various ages, backgrounds and ethnicities. Her subjects, chosen partly for their diversity of experience and age, were selected with the help of front-line workers. Many of Meaghan's subjects are hopeful and vigorous women, which she says is no surprise because "the reality is you have to have a fair number of coping skills to make it out there."

And their stories are varied.

Gillian was a suburban wife and mother whose life took an unexpected turn for the

worse after recreational drug use turned to addiction. She says she thought heroin was "the cool and trendy thing to do," but before long she and her husband lost their jobs and began stealing to pay for their habits.

She later separated from her husband, began prostituting and developed a terminal HIV-related infection. Today Gillian is recovering from her addiction and works as the women's representative at her hostel. But she describes sending her sons to be raised by a relative as "the worst feeling in the world. I let my children down. When you lose your children, what is there left?"

Eighteen-year-old Sarah has lived for the past six months on Toronto streets after being kicked out of her home and losing her job. In and out of foster care most of her life, Sarah's Grade 10 education isn't enough to get her far, though she says, "If somebody would give me a chance I could prove that I am a good worker."

Forty-one-year-old Vivian is a native woman who has lived with her husband in the doorway of an abandoned Toronto building for the past three years. Both suffer from health problems related to chronic alcoholism.

Meaghan points out that Vivian faces extra challenges as a native woman and a woman who is married. There are shelters to accommodate families but almost none for couples.

"I think that goes into the whole ethic that if you're getting a handout from the state, it should be painful," muses Meaghan.

The thrust of her paper refutes this kind of individual blaming and carefully enumerates

the large-scale social factors that have left so many people homeless. These factors include changes to unemployment legislation that disqualify 60 per cent of unemployed Torontonians from receiving benefits. And things like a 21 per cent cut in Ontario welfare benefits and withdrawal of a food supplement allowance for pregnant women.

These cuts come at a time when the cost of housing in Toronto has skyrocketed. The city's vacancy rate hovers at one per cent and the federal and provincial governments have abdicated responsibility for housing to the metropolitan government — without transferring any money to pay for housing starts.

As a result, use of food banks has doubled over the past eight years. (There are currently more food banks in Ontario than McDonald's outlets.) Child poverty has increased by 58 per cent over the last decade. And almost 5,000 people in Toronto are homeless, according to Meaghan's research.

For women — who suffer from a higher rate of unemployment and lower wages, and who are primary caregivers often raising children alone — it means more and deeper poverty.

"We would hope to raise people's awareness," says Meaghan. "The face of homelessness is not the stereotype of an old man on a bench with his bottle. It may be a young woman with a child in a shelter because she's lost her house. And we may all be one job away from it." ■

Bareket's photos and Meaghan's text will be displayed at Toronto City Hall in late October.



Detail from photo by Nir Bareket

Altered sense of smell may indicate problem with brain functioning

JOE MAY SMELL THE SKUNK BEFORE THE rest of his family does, but he may think he's smelling an onion. Like other people with schizophrenia — and possibly those with obsessive-compulsive disorder — Joe is more likely to have problems identifying or recognizing smells, and discriminating one smell from the other. But he is also more likely to smell odours more strongly than most people do.

These are the findings of Dr. Lili Kopala, an associate professor of psychiatry at Dalhousie University in Halifax. She claims that this rather mild yet undoubtedly "altered sense of smell" in people with schizophrenia may be one of the first indications of a problem with brain functioning. Armed with this awareness, Dr. Kopala says psychiatrists and other health care professionals may be able to intervene earlier and thereby improve the outcome of treatment for people with schizophrenia.

She says that men with schizophrenia are more likely to display these olfactory differences than women with schizophrenia, though those women who are post-menopausal have more marked impairments than women of other ages. This suggests that estrogen may affect early brain development as well as later functional influences, according to Dr. Kopala.

Individuals with neurodegenerative disorders may also share this altered sense of smell. In fact, deterioration of sense of smell is one of the earliest signs of Parkinson's and Alzheimer's diseases. Those with Huntington's chorea and amyotrophic lateral sclerosis also have a diminished sense of smell, although it is usually less marked.

"From a clinical perspective," Dr. Kopala says, "assessing olfactory function in certain patient groups may be valuable for differential diagnosis and predicting outcome. If we can detect disease early and treat effectively we may be able to prevent deterioration. Early intervention is critical."

Indeed, people with schizophrenia can actually be classified according to their ability to identify common odours. These two groups — those with altered and unaltered senses of smell — can then be compared with healthy volunteers. "It is a way of directing useful research in the field," says Dr. Kopala, who is also the director of the Research and Community Education Group at the Nova Scotia Hospital in Dartmouth.

Studies conducted on identical twins, in which one twin has schizophrenia and the other doesn't, found that the twin with schizo-

phrenia was often unable to identify common odours. However, the unaffected twin's sense of smell fell midway on a continuum between that of the sibling and a healthy volunteer. If one identical twin shows symptoms of schizophrenia, there is as much as a 50 per cent chance that the other twin will also have symptoms.

"This implied to us that genes are contributing to the development of the brain in such a way that the olfactory pathways are affected. The same findings have been recorded for large families who have a history of schizophrenia," says Dr. Kopala.

One reason that the sense of smell may be affected relates to early brain development. Recent data support a neurodevelopmental cause for some people affected with schizophrenia. Alterations in the sense of smell are characterized according to whether they affect the peripheral or central part of the brain. Peripheral problems may be associated with a decrease in the sharpness of the smell as well as its threshold (how long it takes to smell something). More central problems — such as confusing a skunk with an onion — are associated with identifying, discriminating, recognizing and remembering smell.

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Teens helping teens

[focus on youth]

BY KALYANI VITTALA



Detail from photo by Julia Paul

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IT'S A SUNNY AUGUST AFTERNOON AND MOHAMMED MOSADEQ is enjoying his lunch break away from the hustle of his summer internship as an artist for a Toronto-based on-line magazine.

Dressed in khaki Gap-ad pants and a white golf shirt, the 18-year-old epitomizes the youth culture that is so frequently splashed across marketing campaigns and the media today — smart, driven and self-aware. But...

"All this is a far cry from my life just a few years ago — I had violence all over the place, at home, in school, on the streets," says Mosadeq from Scarborough, who credits his turnaround to L.O.V.E. (acronym for Leave Out Violence), a community-based program that helps kids affected by violence.

Mosadeq, an alumnus and volunteer for L.O.V.E., admits to being a former gang member, and recalls, "I was a troubled kid — I'd beat up other kids — I was going nowhere."

L.O.V.E. is just one example of a growing trend towards participation by youth in programs for youth — particularly those geared towards prevention and early detection of such issues as teen suicide, depression and substance abuse. Teens helping teens, as it were. "The whole idea is that any group knows more about its own issues than we so-called professionals," says Julia Greenbaum, who has worked with youth groups at the Centre for Addiction and Mental Health (CAMH) to help them research and develop their own resources.

The CAMH has hired a youth co-ordinator to help youth get involved in planning, developing and delivering youth-related programs and services. This effort is being spurred on by 1996-97 research that suggests Canadian youth are at a disturbingly high risk of mental health problems: in Ontario, 29 per cent of females and 35 per cent of males between the ages of 15 and 19 report mental disorders, compared to 19 per cent of the general population. Suicide is the second largest killer of youth in this country.

"I think this [involving youth] is the only way to deal with youth issues," says Elsbeth Tupker, a CAMH program consultant who helped to produce *Let 'Em Go: How to Support Youth Creating Their Own Solutions*. The book chronicles the making of a 20-minute video by street-involved youth, offering advice on how to reduce the dangers of street life and substance abuse. Called *Safer With CYPHR* (Concerned Youth Promoting Harm Reduction), the video was two years in the making.

In the case of L.O.V.E, the organization — established in 1993 in Montreal — offers summer camps, leadership training programs and photojournalism courses, says Brenda Proulx, the organization's national director. "We set out to attract youth who would reject traditional models of therapy and ended up using the media model because that is something that saturates every corner of their [youth's] minds today."

One of the results? A newspaper called *One Love* produced by L.O.V.E. kids twice a year which discusses the issue of violence, its causes, impact and prevention. "Although the process is unbelievably therapeutic, it's not set up as therapy," she says.

When it comes to therapy and teenagers, identification and inaccessibility have always been the biggest barriers, says Dr. Nasreen Roberts, associate professor at Queen's University Division of Child and Adolescent Psychiatry.

But she cautions, especially concerning suicide, "Peer counselling has been proved detrimental — some kids see this as glory seeking — and the reality is that those at highest risk — older adolescent males — simply won't seek out these kinds of groups."

Taking this into account, Youth Net, which was developed at Children's Hospital of Eastern Ontario, is another outreach program that goes into classrooms and youth centres. Established in 1996, it takes the form of focus groups where teen and 20-something facilitators help students open up about a variety of "teen" issues. Through a screening questionnaire and discussion, they identify high-risk individuals for suicide and depression, among other mental health disorders, and facilitate treatment with professionals in the field.

"Youth still see [psychiatry] as a pretty scary system," says Lynn Chiarelli, satellite program co-ordinator for Youth Net in Ottawa. "So accessibility is our biggest priority." Since the program began, more than 5,000 individuals have participated.

"I find that youth actually open up to other people their own age," says Louroz Mercader, 16, a Mississauga student who is training to be a Youth Net facilitator for the Halton satellite program that will start up in September. "When you look at what happened at Columbine and in Alberta, it's pretty obvious those kids had real problems but everybody just ignored it. We want to prevent something like that from happening here."

"When you're talking to other kids about your problems and your experiences," says Mosadeq, "you don't have to worry because they don't have any power or control over you. They don't judge you. Adults just can't relate to that." ■

THEN

*I'm angry because of all the abuse. It's finally paying off.
I'm feeling it.*

I'm angry because society looks down on me.

I'm angry because I'm ignored everyday.

I'm angry because I'm lonely.

I'm angry because I've got too much anger bursting out.

So what do I do to release it?

I used to harm others. But now I harm myself. Because I don't care.

I can't care.

I'm screaming right now. But I don't care.

You obviously don't give a s--- either.

So damn you and leave me alone.

NOW

*I have a smile so wide I swallowed the sea. So wide I could swim in it.
Flowers are beginning to grow on the shape of my lips. Waves jump into the air as dolphins surf them. Don't drink from the sea. I built and nourished it with my own heart. Living creatures have lived in peace and joy. Joy I've received and given. Energy so positive it killed the sharks invading the sea. Corals without horizons have settled to the bottom of the sea. Corals of thousands of different colours and shapes. Life has to be lived and nurtured, life has to be loved.*

by Mohammed Mosadeq

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Getting high doesn't have to involve drugs

A PROJECT AIMED AT GETTING YOUNG PEOPLE HIGH ON LIFE is making a slow but steady dent in Ontario communities — where youth might otherwise be getting high on drugs and alcohol.

Targeted to youth between the ages of 12 and 17, High on Life is a unique program that offers young people alternatives to “just saying no.” “Years of experience and research indicate that the negative message, though effective in some ways, doesn’t go far enough,” explains Jeff Wilbee, executive director of the Alcohol & Drug Recovery Association of Ontario, which is developing the project.

Offered both at schools and within the context of various community-based activities, High on Life tries to instill self-esteem and pride in young participants by helping them accomplish whatever may be of interest to them. For example, the recently completed High on Drama project involved a team of young people who both brainstormed and performed a play under the tutelage of older students in a dramatic arts class.

Observers of the vignettes felt they were “rich with thought and imagery” and “spoke to the Grade 8s at their level.” Other examples of High on Life projects involve partnerships with the Grand River Conservation Authority, where a High on Art program is underway to teach elementary school students the history, economics and environmental value of the Grand River watershed through the medium of art, he adds.

In other successful projects, young people in Newmarket are producing their own newspaper, Wilbee says. An interactive High on Sports program is also in place, in which college and secondary school

students speak to younger students about their sports dreams and goals. The same program also brings workshops and sports fests to students, so that they can interact with the likes of the Toronto Raptors and NHL hockey coaches, and hear how they got High on Sports, explains Wilbee.

Mentoring of younger students by older students is one of the elements in the High on Life project. Using role models is another. Fourteen-year-old Jacob Moloy is an example of a young singer who is contributing to the High on Music program. Apart from having just made his first CD, Moloy plays in schools and youth centres where, through his music, he reinforces messages about making responsible choices concerning drugs.

“There’s no preaching here, just songs that have positive messages,” says Wilbee. But the fact that Jacob is a “clean-cut” young guy from a small town who happens to have “his head together” gives young people a chance to feel good while listening to his music and, hopefully, picks up on the theme of feeling good about themselves, Wilbee adds.

“Life isn’t just about bliss. It is being able to face challenges as well. By getting kids through the challenges, we can build [their] self-esteem, and with self-esteem more firmly in place, kids have more strength to resist negative peer pressure that can lead them into unhealthy life choices.”

For more information on High on Life, check out their Web site at <www.highonlife.org>.



Bold new efforts aim to prevent schizophrenia

TEN YEARS AGO, SCHIZOPHRENIA TREATMENT FOCUSED ON working with the most chronically ill. More recently, the focus shifted to working with people when they first develop the illness. And now — well, scientists are trying to identify and treat people before they even become psychotic. In other words, they’re trying to prevent or at best delay the illness from ever occurring.

“This is a pretty bold area to be pursuing,” says Dr. Robert Zipursky, Clinical Director of the Schizophrenia and Continuing Care Program at the Centre for Addiction and Mental Health (CAMH), and the Centre’s principal investigator in a progressive multi-site study.

Partnered with research teams from Yale University, the University of North Carolina, the University of Calgary and Long Island Jewish Medical Centre in New York, investigators will identify and treat 80 people over the next two years for early signs of schizophrenia.

Criteria for the study have been developed based on the work of Dr. Patrick McGorry of the University of Melbourne in Australia who classified people at high risk of schizophrenia as coming under one of three categories:

- siblings or children of people with schizophrenia or a mood disorder who have exhibited a recent decline in their daily functioning — such as withdrawing from family or friends, or doing poorly academically
- people who have only intermittent schizophrenia-like symptoms — such as suspiciousness, paranoia and bizarre thoughts (for example, believing that a radio or TV program is speaking to them directly) —

and who still question or doubt their beliefs

- people who hear voices or have bizarre or paranoid thoughts, but for only brief periods of time.

Dr. McGorry and his colleagues found that 41 per cent of individuals fitting into any of these categories then went on to develop schizophrenia within a year.

The North American multi-site study will involve people as young as 12 and as old as 45. Caution will be used in prescribing medication, as it isn’t yet known whether people with these symptoms will benefit from taking antipsychotics — which are used to treat acute schizophrenia, and often result in significant side-effects, including potentially long-lasting neurological ones. In the first year of the study, half the subjects will be randomly assigned a therapeutic dose of olanzapine (one of the newer antipsychotics) and the other half will be given a placebo.

Caution will also be taken in identifying subjects. As CAMH staff psychiatrist Dr. Irvin Epstein remarks: “Many [people referred to us] may have symptoms that look like depression, such as not eating or sleeping well,” and it will be the clinicians’ job to distinguish between these signs and what are, at times, similar symptoms of pre-psychosis.

As Dr. Zipursky asserts, “Schizophrenia is among the most devastating of all psychiatric illnesses.” If you can intervene early on in a person’s life — before there have been loss of work skills, loss of social skills and disappointments in other aspects of a person’s life, you can make a much greater difference to someone’s future. **DIANA BALLON**



Detail from photo by Julia Paul

Working with the family to break the addiction cycle

BY NANCY DEUTSCH

THE PEOPLE IN THE ROOM DIG INTO A sumptuous home-cooked meal. The group is rowdy, the appearance that of a regular gathering of friends and family. But in this gathering, the food — or rather, the intimate act of eating together — is doing more than nourish the body. If researchers are correct, it is also playing a role in helping adults stay addiction-free, and deterring children from abusing alcohol and other drugs later on.

New family-child initiatives aimed at preventing substance abuse are very specifically designed, encouraging family cohesiveness and incorporating a unique three-pronged approach: adults with substance abuse problems are counselled and given skills on parenting, children participate in groups designed to teach them skills for building strong family units, and then both groups meet together to play games, practise their newly acquired skills, eat and share insights.

The idea of including families in the addicted person's therapy is not in itself new. As Gloria Chaim, Clinical Director of Addiction Treatment Programs for Special Populations at the Centre for Addiction and Mental Health (CAMH) points out, the CAMH has been including families in a number of their addiction programs since the 1970s. "If someone is using, it affects the whole family. It's a system that works together," she explains. "Many addicts relapse when their family is not supportive of the changes wrought by withdrawal."

But the new approaches taken by programs such as Strengthening Families are designed to help break the cycle of substance abuse by building resiliency in the children.

The emphasis on improving family dynamics is based on the belief that parents who learn to communicate with their children are increasingly motivated to deal with their dependency, while children at risk of developing addictions are discouraged from using by developing skills that promote healthy families.

Research suggests there is less of a propensity for substance abuse and violence in children

of people with addictions when there is open communication in the family, according to Scott Macdonald, a scientist in London, Ont., and co-investigator of a study of Strengthening Families' 16-week program.

"We think that when children are better at setting goals, problem-solving, communicating and dealing with emotions, such as anger, they will be less likely to later develop behavioural problems, such as alcohol and drug abuse."

By focusing on communication between parents and children, it is hoped that the parents with addiction problems and their children will enjoy each other more — enough to make some changes, says project manager Susan Lalonde Rankin.

Strengthening Families has been piloted with children aged nine to 12 in several Ontario communities, as well as across the border in Buffalo, N.Y.

"What I think is really unique about the program is the fact that we're comparing its implementation across international boundaries and yet in a similar geographical area [Ontario and N.Y. state, its neighbour to the south]," says Brenda Miller, Director of the Center for Research on Urban Social Work Practice of the University at Buffalo (U.B.). As principal investigator of the research proposal, Miller says they will be comparing how different cultural influences, and differences in provision of health care services, affect how the programs are delivered in the two regions.

The CAMH and U.B. team have jointly submitted a proposal to the National Institutes of Health in Washington to evaluate the long-term impact of the program with nine- to 12-year-olds.

Strengthening Families was developed based on the work of Karol Kumpfer in Utah, who worked with CAMH, Parents Against Drugs and other addiction agencies in Ontario to adapt her model to work with families here. By all accounts, it's succeeding. The vast majority of parents stay free of the addictive substance while on the program, Macdonald says.

REGRET

As the cold hard steel bites my wrists with awakening clicks and pinches, I realize that what I've done is wrong.

But that's not enough, not enough for the big men in blue as they remind me of unstoppable and all-powerful gods, leading me towards what all my thoughts go against. A door. A door like no door seen on any ordinary street or in a hallway, but a door of great strength, driving hopeless thoughts into my mind.

As I enter the room behind the door, I'm struck by the frosty draft driving goosebumps up and down my body. Then, with a shuddering clack of steel, I'm no more a free man and all I can do is stare into the blinding light overhead that drills into my eyes, burning them awake, forever.

I don't like this place, this place of evil, this place of sorrow, this place of total darkness, darkness of the soul and mind as you sit and await the outcomes of your misfortune.

MOVING ON

When I get angry, the best thing I can do is count to 10 or just walk away, but it wasn't always that way with me. In fact, it took the system three years to change my anger.

At first, I would express this poisonous anger by throwing some type of temper spasms, tossing things across a room or just, in general, with pure and unjustified violence.

The violence part of my anger was starting to get in the way, so I took up pot and beer and other toxins to keep off the violence.

So instead of destroying those prize possessions we own in life as a product of anger, I'd sit back and tilt my mind to a whole new realm and just forget about the world. It's so much easier than breaking everything in sight.

The thing is that you can't live your whole life nodding out here and there and running away from reality. You've got to be awake and alive.

And you will most definitely end up behind bars, walking around solving problems with your fists.

It's not worth it. Plus it's so much more relaxing just to move on.

Both pieces by Ian Berard, 18

© 1998 by Leave Out Violence. Excerpted from L.O.V.E. works! photojournalism by the Leave Out Violence teens, ed. Brenda Zosky Proulx, Stoddard Publishing Co. Ltd., 1998.

Q & A

Common questions about mental health and addiction problems among youth



What kinds of warning signs/problems are youth manifesting?

At adolescence, young people begin to test rules and push boundaries as they make the transition from childhood to adulthood. Nearly one-third of 12- to 13-year-olds report stealing something at least once in the past year, while 41 per cent report fighting or threatening to beat somebody up, according to a 1996-97 national survey. On average, young people start smoking at age 14. Not surprisingly, the most common drugs used by Ontario adolescents are alcohol, tobacco and cannabis.

What are some of the risk factors for drug/alcohol and mental health problems among youth?

Suicidal behaviour is one of the most pressing mental health issues among youth — and the second largest killer of youth in Canada. It is frequently linked with depression, anxiety and low self-esteem and may be influenced by family conflict. Adolescents reporting a difficult relationship with one or both parents, for example, were more than five times more likely to have considered suicide in the previous year, according to a 1996-97 national survey.

Other significant risk factors are age of onset — the earlier someone develops a substance abuse problem, the more at risk that person is of developing a more severe addiction problem later on; hostile and ineffective parenting skills; and early childhood physical and/or sexual abuse. Cruelty to animals increases the risk of later violence towards humans. Other factors that place youth at risk for drug abuse include learning difficulties, behavioural problems and the influence of peers who use drugs. Risk factors may reflect a combination of both genetic and environmental influences. If one parent is depressed, a child has a 15- to 17-per-cent chance of getting depressed. This increases to 45 to 50 per cent if both parents suffer from depression. Similarly, a family history of substance abuse increases the likelihood of a child developing an addiction problem.

What are some of the factors that protect youth from developing later problems?

Many children grow up in troubled homes as victims of violence or neglect, yet still they manage to develop into healthy adults. These children are resilient, possessing such attributes as empathy, good communication skills, an ability to problem-solve, a strong commitment to learning in school, involvement in social activities, a sense of optimism and a strong relationship with a caring adult as they grow up. Research suggests that resiliency is a product of being connected to people, interests and the community.

Are street-involved youth at greater risk of developing mental health and addiction problems?

Yes. Street life is stressful and dangerous. The incidence of attempted suicide in this population is 43 per cent, according to recent Canadian data. And yet surprisingly, those who identify themselves as "street youth" show a high level of self-esteem, seeing themselves as survivors and able to manage life on the street. Drinking and drug use is prevalent; 95 per cent report that they drink, and more than 30 per cent report very heavy drinking. One-third also report having drug problems. Unfortunately, street-involved youth have many needs that are not always met by treatment programs. These needs include money, food and shelter, vocational training, supportive housing and mental health treatment.

What are the main reasons for young people to be referred to mental health centres?

Mental health problems in youth are often first noticed as difficulties getting along in school. Problems include academic, learning and behavioural problems, such as attention-deficit/hyperactivity disorder (ADHD) or disruptive behaviour.

What is the gender difference in terms of mental health/addiction problems?

About six to seven boys to every girl are referred to a mental health clinic for acting out or aggressive behaviour — not because boys necessarily have more problems than girls, but because boys tend to externalize their problems, while girls are more likely to internalize them (become depressed). A Yale University study revealed that, while rates of learning disorders were equivalent among school-aged boys and girls, far more boys were referred to mental health clinics for associated behaviour problems. Anxiety and depression are more common in girls after puberty, but are about equally common in boys and girls before.

How important is it to include the family in interventions with youth?

For pre-adolescents, it is rare to have effective treatment without family involvement. About 25 to 30 years ago, the psychoanalytic movement focused on treating the individual to the exclusion of the family. Today, greater emphasis is placed on looking at the family as a system. Parents learn how to show interest, support and concern for their children, and a healthy amount of protection and supervision. The focus is on increasing family members' understanding and communication, without placing blame, either on the child or the parent.

How do you know whether an adolescent is going through a rebellious phase, or whether his or her behaviour is indicative of greater problems later on?

It's difficult to say. Serious problems often depend on how pervasive and diverse the behaviour is, and for how long it persists. If problem behaviour lasts for weeks or months, and affects many aspects of the child's life (friendships or performance at school, including dropping out, seeming unhappy and despondent), parents may want to get a referral for their child to a mental health clinic. Young people who have episodes of depression before puberty are at greater risk of later depressive illness. Youth who indicate a high level of depression are seven times more likely to consider suicide than those who do not.

Who has the most influence on youth — their peers, or their family?

Peers tend to influence the here-and-now, in terms of youth's immediate decisions (such as whether to go to a party or join a gang), whereas life-long values tend to evolve from the family. Of course, a self-selection process may be involved, in that young people don't randomly choose their peer group; rather, they select friends consistent with their needs and interests. If they feel vulnerable or lonely, for instance, they may choose peers who make them feel valued; children who are self-confident and secure tend to be less susceptible to peer influence. More than 80 per cent of adolescents who smoke report having three or more friends who also smoke. While parents' smoking doesn't affect adolescents, "perceived smoking approval" from parents does, according to a 1996 study.

Sources: Dr. Joe Belitchman, Head, Child Psychiatry Program, CAMH; David DeWit, Scientist, CAMH; Andrea Stevens Lavigne, Program Leader, Youth Prevention Program, CAMH; Adlaf, Edward M. et al., Ontario Student Drug Use Survey (1977-1997), The Addiction Research Foundation, 1997; Benard, Bonnie, From Research to Practice, Resiliency in Action, Winter 1996; Canadian Centre on Substance Abuse and Addiction Research Foundation of Ontario, Canadian Profile: Alcohol, Tobacco and Other Drugs, 1997; Harrison, Susan and Virginia Carver, eds., Alcohol and Drug Problems: A Practical Guide for Counsellors, Addiction Research Foundation, 1997; Human Resources Development Canada and Statistics Canada, "National Longitudinal Survey of Children and Youth: transition into adolescence (1996-97)," The Daily, Statistics Canada, July 6, 1999; Stephens T., Morin M. eds., (Health Canada) Youth Smoking Survey, 1994, Minister of Supply and Services, Canada, 1996.

Pat Capponi gives speech to the voiceless

PAT HUNG OUT WITH NIKE AND JOAN in her trek across Canada. In *The War at Home: An Intimate Portrait of Canada's Poor*, Pat Capponi's action—"provoking" new narrative, we encounter a drug addict named Nike who only uses enough to "take the edge off," and Joan, a familiar face for Pat in what would otherwise be a city of strangers. Capponi frames her portrait of Canada's poor both with humour and sobering statistics on national poverty. We don't easily forget the highlights of Capponi's national tour, which illustrate that charity shouldn't always begin at home.

Capponi gives an overview of her cross-Canada trek in her epilogue. She has learned that in Vancouver, more than 2.5 million hypodermic needles were exchanged in a year. And in Montreal, 40,000 hot dogs were handed out to street kids the year before. In Toronto, mats

are given to the homeless as a community service and in St. John's, one of the few visible homeless citizens makes an annual cross-country trek of his own, moving away from high visibility in Newfoundland to places west where the panhandling business is far better.

The author illustrates throughout that women, blacks and gays have fought a "strong battle against negative portrayals" in television and national media, while "the poor, crazy and addicted" don't believe they have this "capability to fight for change."

Across Canada, characters voice their struggle against poverty. We meet Nike and Victor in Vancouver, Joan and Theresa in Edmonton, Pauline and Freda in Winnipeg and Cody and Marian in Toronto. Capponi gives speech to the voiceless.

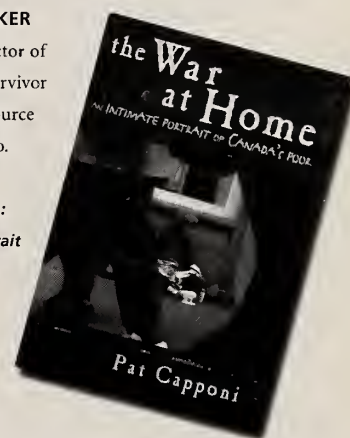
At "Meet the Street '98," a consciousness-raising event which Pat attended at the

Mustard Seed, a church-based community centre in Edmonton, we reflect on this biblical reference: with the faith equivalent to a grain of mustard seed, one can move mountains. In *The War at Home*, Capponi shows us that the poor and their social network need to do just that.

CHRIS WHITTAKER

is Executive Director of the Consumer/Survivor Information Resource Centre of Toronto.

The War at Home: An Intimate Portrait of Canada's Poor, Pat Capponi, Viking, Toronto, 1999, 255 pp, \$32 CDN.



Changing addictive behaviour means more than advocating abstinence

THE RAMPARTS BUTTRESSING THE U.S. government's punitive War on Drugs are systematically stormed in *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies*. Criticism abounds against an initiative for which the book's contributors find no redeeming value.

In fact one wonders after reading the first chapter on historical and contemporary perspectives, how *anyone* could have imagined that such a heavy-handed, moralistic "solution" could ever have worked. If support was initially proffered by any in this quarter, it's been rescinded with a vengeance.

The book, however, is not a rant. Rather, it's a call to reshuffle priorities. The 1994 U.S. federal drug control budget of more than \$12.5 billion tagged a mere \$2.5 billion for treatment and prevention. The rest mostly went to international and domestic law enforcement. Clearly, the authors believe, the economic emphasis is misplaced. But there are other concerns as well.

Not only is drug use stigmatized in the United States, so too is treatment, especially if it is at all permissive (i.e. non-abstinent). "Perhaps our Puritan heritage with its admonitions to

avoid temptation and forbidden fruit has drawn us to favour approaches that emphasize and value abstinence above all else and stigmatize those who fail," remarks Jalie A. Tucker, one of the book's editors.

Whatever the reason, drug users — and the public purse — get short shrift. People with mild or moderate problems who haven't the time nor inclination for intensive abstinent-based treatment, or are unmotivated by 12-step principles culminating in abstinence, are often getting no help at all. This, say drug policy analysts, is an expensive lapse in treatment possibilities, given that "untreated substance abusers access the health care system up to 10 times more often than do non-abusers, and their families receive medical care at a rate up to five times more often than do families of non-abusers."

Changing Addictive Behavior strongly advocates a range of interventions beyond traditional treatments and mutual help groups and devotes a hefty portion of its pages to elaborate "the conceptual and empirical bases for these recommendations," including the brave assertion that sometimes no intervention at all is necessary. This in a book conceived and largely

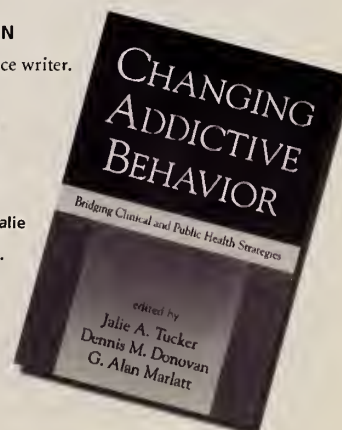
written by clinical psychologists, but ones who recognize that "developments were occurring that required us to move beyond the familiar clinical model and to consider public health approaches to addictive behaviour change."

The second half of the book details some of the public health interventions and concludes that — while less intensive, costly and effective than clinical treatments — they do reach more of the great "under-served" majority of people with problems. Not a bad thing considering that in the book's final chapter on cost-benefit analysis, it's stated that while the number of illicit drug users in the United States has declined since 1985, federal spending to reduce the drug problem has increased 400 per cent since 1986.

BARBARA FULTON

is a Toronto freelance writer.

Changing Addictive Behavior: Bridging Clinical and Public Health Strategies, Jalie A. Tucker, Dennis M. Donovan, G. Alan Marlatt, eds., The Guilford Press, New York, 1999, 387 pp, \$42 US.



Getting tough about crime

Is change to federal law the solution?



BY LINDA BAKER

We welcome submissions from our readers for opinion pieces. For information, contact: The Editor
Journal of Addiction and Mental Health
33 Russell St., Toronto, Ontario M5S 2S1
tel.: (416) 595-6714
e-mail: <journal@camh.net>

BILL C-68 — THE YOUTH CRIMINAL JUSTICE ACT — BRINGS legislation for youth closer to adult law. The special amendments it proposes include codifying proportionate sentences (such that the severity of the sentence fits the severity of the crime, rather than the needs of the offender); expanding the number of offences for which youth as young as 14 can be sentenced in adult court; publishing the names of youth as young as 14 who are given adult sentences or youth sentences for serious violent offences; and introducing a broader array of sentencing options, including non-judicial, community-based alternatives for less serious offences.

The recently proposed Bill C-68 represents a shift in the goals of the legal system, away from the Young Offenders Act (YOA), which emphasized the rights of accused young persons. Under Bill C-68's tougher measures, the primary goal is the protection of society.

Bill C-68 is being intensely scrutinized to determine if it repairs the perceived flaws of the widely ridiculed YOA. Early criticism of the YOA was fuelled by loss of the "wide discretionary power" that judges possessed under the previous Juvenile Delinquents Act, power that gave them the right to determine what was in the "best interests of youth." Antagonism intensified as the "due process framework" — which granted more rights to the accused — was mistakenly blamed for youth falling through the cracks and not receiving needed services. The Canadian public levelled recent pillories of the YOA, with a "get tough on crime" agenda calling for restructuring the youth justice system to lower the age of eligibility to 10 and make community safety the priority.

Such criticism is misplaced. While the federal legislation provides a necessary framework for youth justice in Canada, the Canadian constitution allows provincial and territorial governments to administer that justice. It is this second tier of government that translates what will be put into practice within the particular jurisdiction. Blaming federal legislation for problems in youth justice is akin to blaming the architectural design of a house for the fact that there are no tables and chairs in the kitchen and that there are not enough beds for everyone to sleep at the same time.

We will not know the real impact of the proposed federal legislation for youth justice, especially for those with addictions and mental health problems, until we know what options are implemented in each region. While the bill codifies proportionate sentencing, each jurisdiction will decide how and even whether to implement community-based alternatives to the formal court process, and if so, what those alternatives will be. (One alternative to court is family group conferencing, in which the

offender and his or her family, the victim and possibly the police and members of the community meet together to determine how to respond to the offence.

Even if all provinces implement the same alternative, such as requiring mandatory supervision, the nature of the programs are likely to differ widely. Hypothetically, mandatory supervision for drug offences in one province could mean reporting bi-weekly for 10 minutes and giving a urine sample; while in other, it might mean reporting weekly for 45 minutes, giving a urine sample and receiving bi-weekly home or school visits.

At this time, I believe that service providers need to focus on intense lobbying of their own provincial or territorial government to ensure that

any new laws are consistent with evidence-based knowledge about what works. How successful our lobbying efforts are will be seen in how we define youth justice in our jurisdiction, and will shape the potential impact for youth with addiction and mental health problems.

We need, for example, to pressure governments to implement community-based alternatives for troubled youth who commit less serious

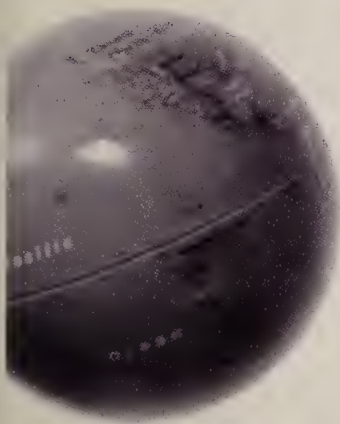
offences, and ensure that mandatory supervision and reintegration plans are implemented. Youth justice and mental health workers have repeatedly called for follow-up or aftercare services for youth released from custody to make it easier for them to reintegrate into the community, and reduce recidivism. Again we must lobby further for these options, advocating that they actually address the needs of youth, rather than merely manage risk.

Lobbying efforts must also push for adequate resources and supports to sustain effective programming. Funding needs to be directed to programs and delivery models that respond to the needs of clients, rather than allowing these programs to be driven by the skills and resources of providers.

The shift in emphasis towards a crime control framework, and its inherent focus on community safety, brings with it an increased role for mental health professionals to predict youth's risk of reoffending. Professionals need to step back and assess what our present models for risk prediction realistically allow us to contribute, how these contributions are going to be used, and what the impact will be for our young clients. Potentially, we are standing on a slippery slope that requires that we be pro-active. ■

Linda Baker, Ph.D., C.Psych, is Assistant Director of the London Family Court Clinic Inc.

Conferences



CANADA

The Canadian Association of Suicide Prevention and the Helpline Society – Toward 2000: New Light on the Issue of Suicide

October 13–16, Halifax, Nova Scotia.
Contact: (902) 422-2048.

8th Annual David Berman Memorial Dual Disorder Conference

October 14–15, Vancouver, British Columbia. Contact: Laurel Lafant, Dual Diagnosis Program, 1-520 Powell Street, Vancouver, BC V6A 1G9, tel (604) 255-9843, fax (604) 251-4579.

Canadian Society of Addiction Medicine, 11th Annual Scientific Meeting

October 15–17, Montreal, Quebec. Contact: Dr. Suzanne Brissette, tel (514) 281-2121, ext. 6553, fax (514) 281-2181, e-mail <brissette.suzanne@sympatico.ca>.

10th International Clubhouse Seminar: An International Seminar on the Clubhouse Approach to Psychiatric Rehabilitation

October 16–21, Toronto, Ontario. Contact: (416) 323-0223, fax (416) 323-9843.

International Association of Psychosocial Rehabilitation Services (IAPSRs), Ontario Chapter, 5th Bi-Annual Conference

October 20–22, Niagara Falls, Ontario. Contact: Sheila Bristo, tel (905) 641-5222.

A Symposium on Girlhood Aggression

Oct 22–23, Toronto, Ontario. Contact: Marion Thirsk, Earls Court Child and Family Centre, 46 St. Clair Gardens, Toronto, ON M6E 3V4, tel (416) 654-8981, ext. 106, fax (416) 654-8996, e-mail <mailus@earls court.on.ca>.

Association des intervenants en toxicomanie du Québec inc. – Toxicomanie et violence: agir ensemble

Le 24 au 27 octobre, Trois-Rivières, Québec. Contact: Chantal Denis, tel (450) 646-3271, e-mail <aitq@pixelweb.com>.

Psychosocial & Psychotherapy Interventions in Cancer Genetics: Challenges, Opportunities & Innovations

October 28, Toronto, Ontario. Contact: Mary Jane Esplen, tel (416) 586-8595, fax (416) 586-8654, e-mail <maryjane.esplen@utoronto.ca>.

INPUT: The 13th Canadian Biennial Symposium on Employee & Family Assistance Programs in the Workplace

November 7–10, Ottawa, Ontario. Contact: Frank Fallon, tel (416) 675-6622, ext. 447, fax (416) 675-0135, e-mail <fallon@admin.humber.on.ca>, web <www.humber.on.ca/~input>.

National Association of Dual Diagnosis Conference (developmental disability and mental health needs)

November 10–13, Niagara Falls, Ontario. Contact: Susan Morris, tel (914) 331-4336, e-mail <nadd@ulster.net>, web <www.thenadd.org>.

Schizophrenia in 2000 – New Directions

November 12, Toronto, Ontario. Contact: Philip AbdelMalik, Centre for Addiction and Mental Health, Queen St. site, tel (416) 535-8510, ext. 2705, fax (416) 535-7199.

UNITED STATES

Canadian Academy of Child Psychiatry / American Academy of Child and Adolescent Psychiatry Annual Meeting

October 19–24, Chicago, Illinois. Contact: AACAP, Meetings Dept., 3615 Wisconsin Avenue NW, Washington, DC 20016-3007, tel (202) 966-7300, ext. 101, e-mail <meetings@aacap.org>, web <www.aacap.org>.

National Education Association for Homeless Children and Youth Conference

November 6–9, Orlando, Florida. Contact: National Education Association for Homeless Children and Youth, tel (805) 599-8483.

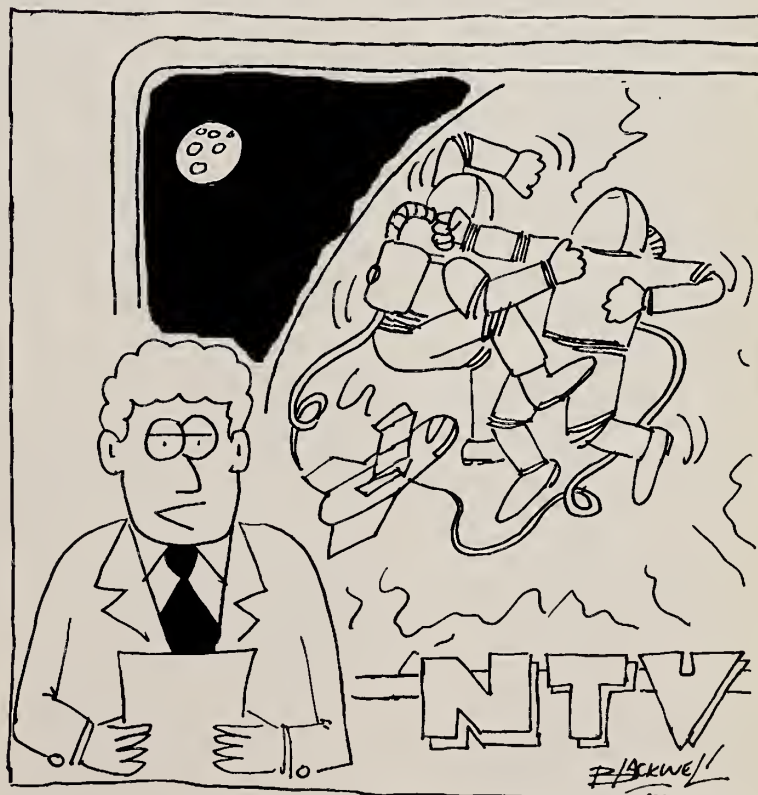
American Public Health Association: 127th Annual Meeting and Exposition

November 7–11, Chicago, Illinois. Contact: American Public Health Association, tel (202) 777-2742, fax (202) 777-2534, web <www.apha.org>.

Preventing Heroin Overdose: Pragmatic Approaches

January 13–14, 2000, Seattle, Washington. Contact: Nancy Sutherland, 3937 15th Ave. NE, Seattle, WA 98105-6696, tel (206) 543-0937, fax (206) 543-5473, email <ada@u.washington.edu>, web <depts.washington.edu/ada/conf/heroin.htm>.

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Conferences

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European Symposium on Community Action to Prevent Alcohol Problems: European Network on Local Alcohol Prevention, Research and Evaluation

November 18–20, Porto, Portugal.
Contact: Symposium Secretariat, Centro
Regional de Alcoologia do Porto,
Rue Professor Alvaro Rodrigues,
4100-040 Porto, Portugal.
tel + 351 2 610 01 82,
fax + 351 610 25 92,
e-mail <alcohol@mail.telepac.pt>.

1st International Congress of Doctoral Research on Social Psychology

February 8–11, 2000. Barcelona, Spain.
Contact: Conference organizers,
e-mail <international.congress@
cc.uab.es>.

Jersey 2000: 11th International Conference on the Reduction of Drug Related Harm

April 9–13, 2000. Jersey, Channel
Islands, British Isles. Contact:
e-mail <hrc@hit.org.uk>,
web <http://www.jersey2000.co.je>.

Psychology After the Year 2000

June 14–24, 2000, Haifa, Israel.
Contact: Azy Barak,
tel + 972 4 824 9374,
fax + 972 4 824 9353,
e-mail <azy@construct.haifa.ac.il>,
web <http://construct.haifa.ac.il/
~azy/couninet.htm>.

2nd International Congress of Licensure, Certification, and Credentialing of Psychologists

July 18–20, 2000. Oslo, Norway.
Contact: Norwegian
Psychological Association,
fax +47 22 42 42 92,
e-mail <npfpost@psykol.no>.

27th International Congress of Psychology

July 23–28, 2000. Stockholm, Sweden.
Contact: XXVII International Congress
of Psychology,
tel + 46 8 24 78 55,

fax + 46 8 24 78 55,
e-mail <psych.congress.2000@
psykologforbundet.se>.

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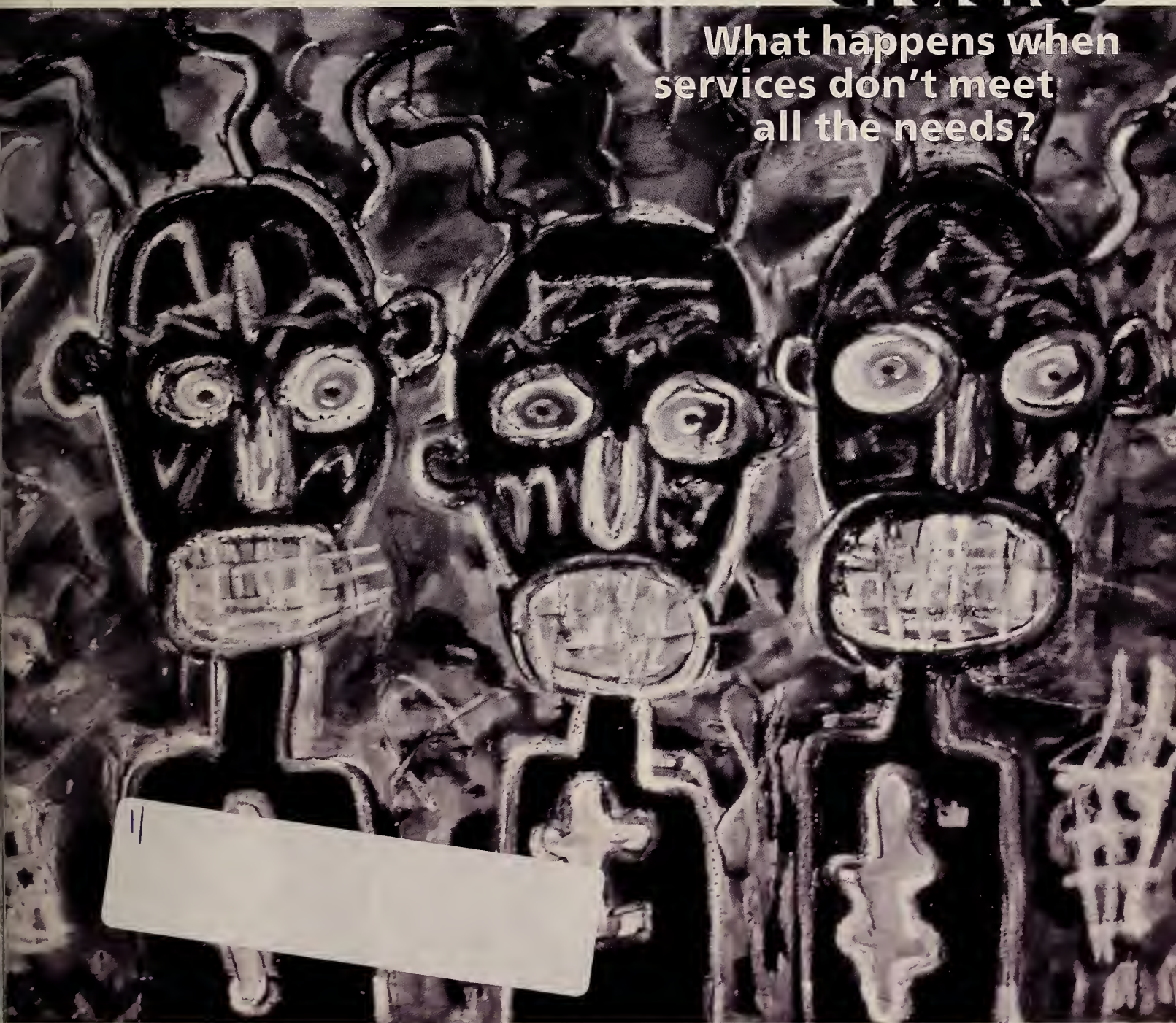
January/February
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PERIODICALS READING ROOM

Humanities & Social Sciences

**Falling
through
the cracks**

What happens when
services don't meet
all the needs?



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Wrestling with life's
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**TOO SCARED
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How trauma
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Treating psychosis at
onset reduces recurrence



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Highlights

Early intervention crucial

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Ushering in a new approach

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addiction treatment for women 4

Ontario students use more drugs

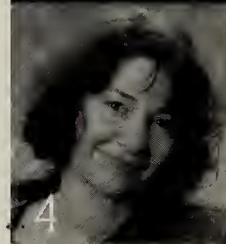
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On-line therapy or addiction?

Excessive Internet users may be
substituting technology for chemicals 10



LISA SCHMIDT is a writer, editor and graphic artist. She was recently hired as the internal communications co-ordinator at the Centre for Addiction and Mental Health.



HONEY FISHER is a Toronto-based freelance writer, editor and filmmaker. She worked for several years as a researcher at the former Addiction Research Foundation.



CHRISTA HAANSTRA is the media relations co-ordinator at the Centre. Her work on the release of the drug survey generated more than 150 media mentions across the province.



PAUL JAY is a freelance writer and editor living in Toronto. His writing has appeared in such publications as *Saturday Night*, *National Post Business Magazine*, *The Toronto Star* and *This Magazine*.

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Cover

Menno Krant
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mixed media
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Krant is profiled
on page 8.



News from the Centre

Underlying all of the Centre's efforts are two principal tasks: advancing our understanding of mental health and addiction, and translating this knowledge into practical resources and tools.

The Centre has embarked on Canada's most aggressive program to improve understanding, prevention and care of mental illness and addiction. With the support of the Centre for Addiction and Mental Health Foundation's *Centred on Hope Campaign*, it is close to its goal of \$10 million. This campaign will fund the critical priorities of the Centre including:

- the **Community Mental Health Program**, which will work with existing programs to identify and implement best practices in supportive communities;
- the **Children and Youth Initiative**, which will improve work on prevention, early detection and improved care;
- the **Women's Mental Health Program**, which will identify women's mental health problems, train clinicians and academics and develop effective new models for care that are responsive to the needs of women;
- **Acute and Emergency Care**, identified as one of the keys to reforming Ontario's Mental Health System, which will teach more people how to handle those in crisis;
- the **Education and Training Centre**, which will improve the Centre's ability to provide educational opportunities to the more than 600 university students in all health care disciplines, and 6,000 Ontario professionals who receive some of their education at the Centre each year.

Three Chairs and two Professorships will also be created and implemented with the University of Toronto:

- The **Cameron Parker Holcome Wilson Chair in Depression Studies**, named for the

late son of the Honourable Michael and Margie Wilson, will set new standards of care and research as well as educate others about this group of disorders.

- The **Chair in Addiction Psychiatry** will provide a resource for research, training and public education and will help to integrate new addiction and mental health knowledge.
- A **Professorship in Behavioural Neuroscience** will enable us to translate basic science breakthroughs into improved patient care.
- The **Professorship in Mental Health Nursing** will drive evidence-based practice through directed research and provide real experience in adapting clinical environments for better patient care.
- The **Aboriginal Community Alcohol Policy Project** will develop a culturally sensitive model for the community to introduce alcohol management and prevention strategies.
- A **Chair in Addiction and Mental Health Policy** will be developed to lead a team of scientists to provide evidence-based recommendations guiding policy.

For further information, please contact the Foundation at (416) 979-6909.

In other news, the Centre launched its anniversary celebrations, *Many Histories, One Future*, last November with a tribute to the former Addiction Research Foundation (ARF)'s 50th year. The celebrations included a lecture and tribute to H. David Archibald, founder of the ARF and a pioneer in the addiction field in Canada. The Centre will also recognize the 150th anniversary of the former Queen Street Mental Health Centre, and the 75th anniversary of the Department of Psychiatry at the University of Toronto, through a series of events over the next year.

RENA SCHEFFER

Letters



"Huggable ravers" usually don't do drugs

As an active member of the rave culture, I would like to respond to Gerry Luciano's article on rave drugs. Mr. Luciano is mistaken in his assumption that drugs are the focus of rave culture. Raves are a social phenomenon, drawing together thousands of people of all ages internationally. They are built around togetherness and spirituality – and principles of peace, love, unity and respect. Raves are safe environments for people to escape from discrimination and stress, mostly without the use of drugs.

Many ravers recognize the spiritual element in raving as the main reason for coming back time and again. These parties are reminiscent of early tribal gatherings when people danced together to rhythmic music, revelling in the energy created.

Rave culture may be declining in quality (because of over-commercialization), but the basic principles aren't going anywhere. If anything, the parties will head underground, far away from the parents, hospitals and support systems that people who get into trouble will need. It is a shame when spiritual minorities are repressed, as that is when they develop more secretive and dangerous ways to express themselves. Maybe then it will be necessary to search the crack houses for those once huggable ravers who just want a chance at discovering inner peace among a group of like-minded thinkers.

WE MUST EDUCATE OURSELVES AND EACH OTHER.
IT IS OUR ONLY CHANCE FOR SURVIVAL.

Jessica Krippendorf

1st-year journalism student

Malaspina University-College, Duncan, B.C.

Please send letters to:

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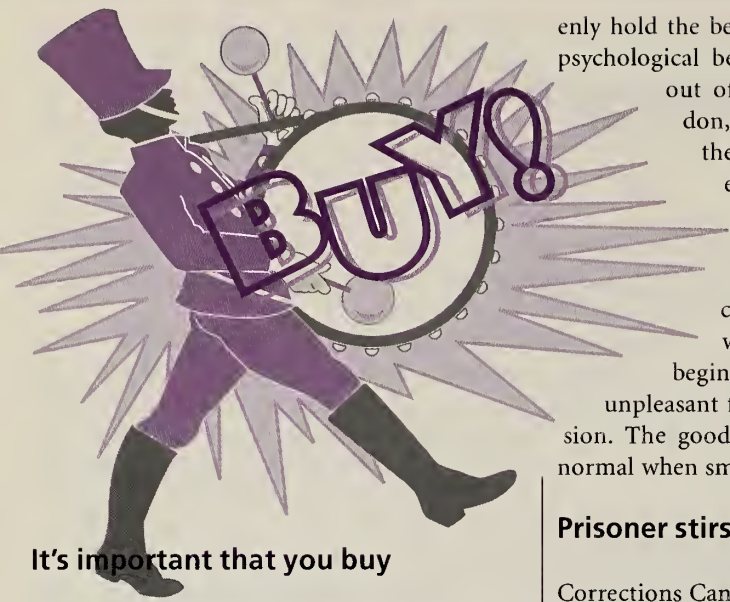
This newly launched consumer health site provides a national Internet-based information service for the Canadian public by connecting health networks across the country. Canadian Health Network (CHN), developed in partnership with 400 health organizations, features in-depth resources relating to 26 major health topics that include substance use, tobacco and mental health. Although early in its development, the site already offers an impressive array of information, and it is easy to use. Just select a topic and then narrow it by group, type of resource or province.

Tapping Health Canada

<www.hc-sc.gc.ca>

Health Canada is a must for your bookmarks. Keep up to date with the latest news releases. To zero in on mental health and addiction-related news, reports and publications, take the Express Lane **Health Promotion On-Line** <www.hc-sc.gc.ca/hppb/hpo> and scroll through the **Health Issues and Programs** index for related topics. Under **Mental Health**, information of all levels and types can be found, from aging and seniors to **Mental Health Service Systems**. The latter includes **Best Practices in Mental Health Reform**, published in 1997 by the former Clarke Institute of Psychiatry. SHEILA LACROIX

In Brief



It's important that you buy

Harvard researchers have discovered “buy, buy, buy” brainwaves that are created whenever consumers encounter an article they like. The same team has also found brainwaves that correspond to feelings of rejection and to the response, “I’ll come back later.” As the first study to examine the unconscious mind of the shopper at work, some consumer groups worry that it will allow retailers and producers to brainwash consumers. The study was funded by large corporations wanting to design better products and anticipate consumer needs.

New domestic violence guidelines

The U.S. Family Violence Prevention Fund recently published a series of guidelines designed to help health professionals screen their clients for signs of physical abuse. Among other practices, the document *Preventing Domestic Violence: Clinical Guidelines on Routine Screening* suggests that caregivers should ask about domestic violence with all women over the age of 14, whether or not signs or symptoms of abuse are present. Nearly four million American women are victims of physical abuse each year. For more information, check out the Family Violence Prevention Fund Web site at <<http://www.fvpf.org>>.

But it helps me to relax

Smokers who cling to their habit because they feel it helps them to relax may actually be increasing their levels of stress and anxiety. Though the majority of smokers are aware that smoking is physically unhealthy, they mistakenly

only hold the belief that smoking has positive psychological benefits. According to research out of the University of East London, smoking causes stress due to the physical and psychological effects of dependency. Though stress levels of smokers are on par with non-smokers immediately after enjoying a cigarette, between cigarettes – when plasma nicotine levels begin to wane – they experience unpleasant feelings of irritability and tension. The good news: stress levels return to normal when smokers kick the habit.

Prisoner stirs controversy

Corrections Canada has agreed to allow one of its prisoners to undergo sex-change surgery and to complete “her” sentence in a women’s prison. The settling of Synthia Kavanagh’s human rights complaint has been greeted as a victory for transgendered individuals both within and outside the prison system. Kavanagh was sentenced to life in prison for the 1987 murder of a transsexual prostitute. The Vancouver Rape Relief and Women’s Shelter has expressed concern about the wisdom of allowing a convicted murderer in a maximum-security male prison to be transferred to a women’s facility. Eleven other requests from prisoners for gender reassignment surgery are still pending.

Harm reduction behind bars

An internal Corrections Canada study indicates that providing needle exchange programs and tattooing services for its prisoners would reduce the spread of infectious disease among inmates. Canadian prisoners have 10 times the infectious rate of HIV/AIDS than the rest of the country, while roughly a third of all inmates have hepatitis C. Tattooing in prisons is a way of life, with as many as 90 per cent of prisoners leaving jail with a new tattoo. The current practice of providing inmates with bleach to clean their needles has apparently done little to prevent the spread of infectious disease.

Butting out the herbal medicine way

Health Canada recently approved a nicotine-free smoking deterrent for adolescents to use

without a prescription. Developed by Paradise Promotions Ltd., *Butt Out* is an orally taken herbal medicine made from *Lobelia Inflata* (a flowering plant indigenous to Eastern Canada and the United States), which acts by blocking nicotine from reaching pleasure centres in the brain. It has a 40 per cent success rate, according to clinical herbalist Dr. Terry Willard. Of all Canadian 15-year-olds still smoking today, more than half will die of smoking-related complications by the time they’re 70. *Butt Out* is currently available in pharmacies and health food stores across Canada.

Putting testing to the test

Workplace drug testing has been found to be ineffective in reducing drug use and absenteeism and in improving productivity, according to an American Civil Liberties Union report. Once considered controversial, drug testing is now a common practice in the American workplace. The prevalence of drug testing in U.S. companies soared from 21.5 per cent in 1986 to 81 per cent in 1996. Though most employers believe that the practice reduces employee drug use, this view is based on anecdotal accounts, rather than a cost-effective analysis, according to an American Medical Association (AMA) study. Even though the AMA has found that it can cost as much as \$70,000 (U.S.) to find one offending worker among a company’s entire staff, the practice continues. Critics see this as a way of placating stockholders’ concerns about America’s drug crisis.

Canadian peacekeepers depressed

Canadian peacekeepers who served in Croatia had a rate of depression three to four times higher than that of the civilian population, according to a 1996 Canadian Armed Forces survey. This percentage is particularly significant, given that the Canadian Forces screens its applicants for histories of mental illness and addiction. Though no explanation for this increased rate of depression was included in the report, almost all those surveyed were exposed to incidents that may have led to post-traumatic stress disorder. The Canadian soldiers who served in Croatia were witness to ethnic cleansing and fierce combat, and may have been exposed to toxic soil.

CHRIS HENDRY

Intervening early reduces psychotic episodes

DESPITE WESTERN SOCIETY valuing, even glorifying, youth and youth culture, most teens claim that few adults take them seriously. For teens struggling with the onset of mental illness, this trivialization can be particularly devastating.

Ian Chovil has lived the consequences of his mental health not being taken seriously. His life has been coloured by a gradual onset of psychosis, which began when he was 18, and went untreated for 10 years. Though he was initially referred to a psychiatrist for what he believed to be an undetectable form of syphilis, and was subsequently hospitalized and later medicated, his delusions, fears and hallucinations were never asked about or listened to. Thus began a decade of homelessness, alcoholism and eventually, incarceration. "That part of my life was a total waste," says Chovil, reflecting back.

Several studies reveal that there is a delay of about three to four years – in Chovil's case, a decade – between the onset of schizophrenia, its intensification and eventual diagnosis and treatment. This time lapse has been identified as the "duration of untreated psychosis." But thanks to the efforts of mental health care professionals, the delay is slowly being reduced.

In British Columbia, for instance, the provincial government recently allocated a million dollars to assist in implementing recommendations that emerged from a CMHA B.C. Division study. The study showed that when early signs of psychosis were identified by caregivers, when access to care was immediate and non-threatening, and when thorough information was presented to teens and their families at the time of diagnosis, recovery from first episodes of psychosis was faster, and could be an isolated event in a young person's life.

The consequences of not treating people at an early stage can be dire. The longer an individual is psychotic before being treated, the poorer that person's eventual outcome, says Dr. C. Shammi, service chief of the Medication Assessment Program, Schizophrenia at the Centre for Addiction and Mental Health. Ninety per cent of people

with schizophrenia who have had only one psychotic episode will respond well to antipsychotics, Dr. Shammi says. However overall, about 25 per cent of chronic patients with schizophrenia (those with an illness lasting longer than two years) will, over the course of their lifetime, eventually fail to respond, and another 40 to 50 per cent will only respond partially to conventional antipsychotics.

There are social implications of delaying treatment as well. As Eric Macnaughton, the CMHA B.C. researcher, remarks: "When you don't make it easy to intervene at an early stage, police involvement is often the first point of contact." To complicate matters, he adds, mental illness is masked by substance abuse in young people.

The treatment model envisioned by the B.C. mental health system is loosely based on the work of the Early Psychosis Prevention and Intervention Centre (EPPIC) in Australia. EPPIC's goal is to educate teens and young adults about mental illness and help those with a diagnosis lead healthy and productive lives. Their studies confirm that early intervention prevents subsequent problems such as substance abuse, unemployment and behavioural problems from becoming deeply entrenched.

Though Chovil's hope of working in mineral exploration is dashed, he is employed as a community education facilitator at the Homewood Centre in Guelph, Ontario. His job includes going to schools and telling grade 11 students about his life and what mental illness is. "These kids are on the cusp of developing relationships, moving out of their parents' homes and starting careers. It's a rare opportunity for them to see what their next few years could be like if they developed mental illness and it went undiagnosed." He adds, after a moment's pause: "What I do now just might help prevent someone, someday from going through what I did."

Ian Chovil can be reached through his Web site at <www.mgl.ca/~chovil>.

LISA SCHMIDT

Managing schizophrenia

On December 2, nurses, social workers and occupational therapists packed a CAMH auditorium to learn more about how to medically manage people with schizophrenia in the community.

"The old system used to discharge people for treatment-resistant illness, rather than acknowledge it as a treatment-resistant system," said Dr. Joan Bishop, a psychiatrist and member of the London Psychiatric Hospital's Program of Assertive Community Treatment (PACT).

ACT teams represent a new way of responding to the needs of people in the community. These teams work around the clock, offering intensive, flexible services to a high needs population – many of whom have had frequent and long hospitalizations, concurrent medical problems, a co-morbid substance abuse problem and a life mired by ongoing crises.

ACT teams offer services in a high worker-to-client ratio (about 10 or fewer clients to one worker), to deal with the concerns of the client, wherever that person may be. For the team from the London Psychiatric Hospital, those experiences included dealing with a clogged toilet when one client tried to flush down a bowl of popcorn. It also included driving another client to the dentist, while role-playing how he could interact with the receptionist.

Another role of community workers has been to manage their clients' medical needs. Ten years ago, the assumption was that people needed to be treated with aggressive doses of medication. Now there are more options, said Dr. Alan I. Green, director of the Commonwealth Research Center, Harvard Medical School in Boston. This means not necessarily increasing dosage levels, but aggressively trying different trials of drugs to find the best one.

The newer atypical antipsychotics reduce not only the positive or more overt symptoms, such as hallucinations and delusions; they also reduce negative symptoms – such as apathy and lack of motivation, as well as cognitive deficits (ability to pay attention and remember things) and mood, Dr. Green said. As a result, many people with schizophrenia are now better able to work, relate to others and live independently, he said. **DIANA BALLON**

Ushering in a new approach to women and addictions

FOR A LONG TIME, WOMEN WERE TREATED AS A SUB-population with special needs. That just marginalizes people. Women have needs. Period." This is the kind of comment that has put Nancy Usher at the forefront of reform into addiction treatment for women.

Usher's involvement in the field first began in 1989 when, out of the blue, she received a telephone call from a headhunter saying that the Jean Tweed Treatment Centre needed an executive director. And could she please come in for an interview.

Midway through the interview, Usher had a sinking feeling that she had the job, despite never having worked in the addiction field. Until then, she had been a psychiatric nurse and clinical director of a community mental health centre. Luckily, she put aside her fears and accepted the challenge.

Usher has come a long way since that day. This past November, she was presented with a Community Achievement Award in recognition of her long-standing dedication to providing effective services for women and their families and for her commitment to enhancing the addiction treatment system in Toronto and the province.

The Jean Tweed Centre, established in 1983, was one of the first treatment centres exclusively for women with chemical dependencies. Shortly after Usher took over the reins, she was shocked to find that almost 80 per cent of the women at the centre had also experienced some sort of physical, sexual or emotional abuse. "It was so obvious, I don't know how we were missing it," said Usher. She later pioneered a treatment approach that addressed both addiction and abuse.

"When I came onto the scene, addiction was generally viewed as an entity unto itself, in isolation from all the other [social, political and

economic] issues in a person's life. I never believed that [these issues were separate]."

Soon after, she identified another issue that had been ignored in addiction services. "I realized that the women leaving treatment were anxious about parenting issues after becoming drug-free. We needed a centre for women and children together."

So Usher formed collaborative partnerships with a variety of organizations, and was able to create "Breaking the Cycle," a unique service that integrates child welfare and addiction services. Next on the drawing board are brand new facilities for a multifunctional centre that will support an environment where women and their families can have their addiction services needs met under one roof. The new centre will also incorporate services to help pregnant, homeless and addicted women deliver healthy babies and learn parenting skills.

Usher has given women a voice in addiction services yet is modest about her achievements. "I don't know why I was nominated for this award. I was just doing what needed to be done. But now that I look back, I realize some really important things have been accomplished. And it's not going to stop here." **HONEY FISHER**



Nancy Usher is a member of the Board of Trustees at the Centre for Addiction and Mental Health.

Transforming the funding of medical research

BY APRIL 1, THE NEW CANADIAN Institute of Health Research (CIHR) may well transform the way medical research is funded in Canada.

Researchers have been invited to submit their ideas for a full slate of institutes to the CIHR. Although they will have leadership, a peer review process and funding, the 10 to 15 institutes will not exist as separate physical entities. Rather, researchers will be linked across a broad spectrum of themes so that they can share knowledge and work towards common goals.

The four "cross-cutting themes" have been identified as basic biomedical research; applied clinical research; research on health care systems and services; and the society, culture and health of populations. The currently existing Medical Research Council (MRC) will become part of the new CIHR, once it is constituted.

Dr. Heather Stuart, associate professor of community health and epidemiology at Queen's University in Kingston, Ontario, has been a principal investigator in a research team

responsible for proposing a design for a mental health institute.

"It's definitely different from the old system which emphasized biomedical research," said Stuart, "because it raises the stature of areas that have been underfunded. With the previously declining budgets, researchers didn't have much of a future in Canada. The new developments and funding will make Canada more internationally competitive."

While proposals have been submitted recommending separate addiction and mental health institutes, she acknowledged that a single institute covering both areas would still work. In either case, the goal will be to collaborate more widely across the four theme areas.

Eric Single, a research associate with the Canadian Centre on Substance Abuse, believes that substance abuse deserves its own institute. He says that out of 22 institute proposals developed and presented, five wanted to include addiction. "Not one of those proposals includes all aspects of addiction so they get lost in other institutes like public health," he said.

"Although the identities of the institutes are important, what is especially important is that every researcher will find a home in this new system," said Dr. Franco Vaccarino, vice-president of research at the Centre for Addiction and Mental Health and professor in the departments of psychiatry and psychology at the University of Toronto. As a member of the Interim Governing Council (IGC) of the CIHR, Vaccarino has been helping to set up a transitional program for the CIHR.

He stressed that the focus should not solely be on concerns about the identity of institutes, but rather on inclusivity (ensuring a home for health researchers within the new structure), and increasing resources and commitment to the four CIHR themes.

"It's nothing but a good news story, especially when you look at the doubling of funding over three years which will start to correct the years of underfunding," says Vaccarino.

For more information on the CIHR, refer to its Web site at <www.cihr.org>. **DEBORAH ETSTEN**

DRUG, ALCOHOL AND TOBACCO USE among Ontario students is on the rise, according to the 1999 Ontario Student Drug Use Survey (OSDUS) by the Centre for Addiction and Mental Health (CAMH).

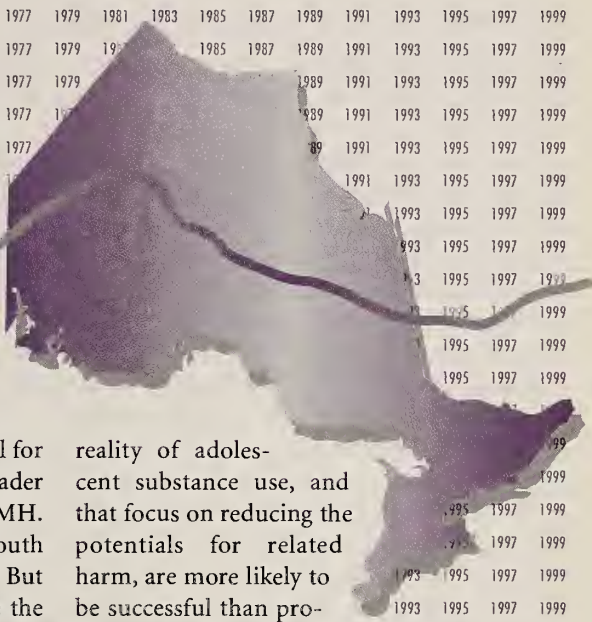
"The 1999 survey results confirm the continuing upswing in drug use among Ontario youth that we have been seeing since 1993," says Dr. Edward Adlaf, the CAMH's lead scientist for the OSDUS, and an assistant professor at the University of Toronto. "During the 1980s we witnessed large declines in student drug use. However since 1993, use of drugs has been moving upward, to the point where current rates do not differ appreciably from the late 1970s."

In 1999, 11 per cent of Ontario students reported hazardous drinking, and 40 per cent of those students also reported impaired men-

tal health. In addition, 6.5 per cent of students reported being unable to stop using drugs, which is more than double that of 1997.

Results of the OSDUS have helped provide the basis for Ontario youth programming as it relates to drugs and alcohol. The CAMH has been doing this survey with the co-operation of Ontario schools since 1977. The highest rates of drug use were seen in 1979; however, this year's figures are almost as high.

"These statistics should be a wake-up call for everyone," says Andrea Stevens Lavigne, leader of youth prevention programs for the CAMH. "There is no secret formula to teach youth about the dangers of alcohol and drug use. But we do know that programs that recognize the



reality of adolescent substance use, and that focus on reducing the potentials for related harm, are more likely to be successful than programs that focus on abstinence alone.”

In the CAMH's most recent Best Advice Paper, *Alcohol and Drug Prevention Programs for Youth: What Works?*, a number of recommendations address this problem. Alcohol and drug prevention programs should be realistic, taking a harm reduction approach, and be based on practical educational principles – not ideology. They should be comprehensive and ongoing from kindergarten to the final year of high school. Youth should be involved in the planning and implementation process. Adults should be aware of the alcohol and drug use trends and informed about drug education. And an ongoing evaluation should continue to reveal which programs work and which don't.

CHRISTA HAANSTRA

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Since 1993:

- The percentage of students who drink alcohol rose significantly to 65.7 per cent from 56.5 per cent in 1993. Of equal importance, more students reported weekly drinking, and drinkers reported more episodes of heavy drinking (consumption of five or more drinks on a single occasion).
- Cannabis has been on a significant upward swing since 1993, with 29.2 per cent of students reporting use over the past year.
- Although rates of smoking have been stable since 1995, the 1999 rate of 28.3 per cent is significantly higher than 23.8 per cent in 1993.

A copy of the Best Advice Paper can be obtained by calling (416) 979-4250.

Research Update

Stalkers lack social skills

The majority of stalkers are lonely and socially incompetent, tending to come from the more disadvantaged strata of society, according to an Australian study of 145 stalkers. Fifty-two per cent of those studied had never had an intimate relationship, while 39 per cent were unemployed. The stalkers' motivations ranged from reasserting power over a partner who rejected them to the search for a loving relationship. The study recommends a combination of appropriate legal sanctions and therapeutic intervention to bring an end to stalking. The authors note that most stalkers stop when threatened with legal prosecution, while therapy and support can help stalkers to abstain from reoffending. **M.H.**

American Journal of Psychiatry, v. 156(8):1244–1249.
Paul E. Mullen et al., Victorian Institute of Forensic Mental Health, Melbourne, Australia.

Alcohol linked to accidents

Alcohol intoxication and alcohol abuse increase an individual's likelihood of becoming an accident victim or of becoming involved in violence, according to a Swedish survey. Reviewing studies from around the world, researchers found that the risk of an accident and the severity of an accident increase with the level of intoxication. Younger males are more likely to become involved in violence and alcohol-induced accidents (particularly motor vehicle accidents) than the rest of the population. Even among pedestrian victims of traffic accidents, the victims were found to be five times more likely to be intoxicated than other pedestrians. The use of alcohol and narcotics also figures prominently in acts of violence, both among perpetrators and victims. Studies out of several countries indicate that alcohol is present in the autopsies of between one-third and one-half of all suicide victims. **M.H.**

Alcoholism: Clinical and Experimental Research, v. 22(7):299S–306S. Bo Brismar and Bo Bergman, Karolinska Institute, Huddinge Hospital, Huddinge, Sweden.

Stimulants reduce substance abuse in ADHD

Contrary to the public's fears, treating attention-deficit/hyperactivity disorder (ADHD) with stimulants significantly reduces the risk of substance abuse later in life. A four-year Massachusetts study of 212 subjects (75 with ADHD) found that youth with ADHD who were treated with stimulants were 85 per cent less likely to abuse alcohol and drugs at the end of the study than were those whose condition was left untreated. In addition, overall levels of substance abuse among the treated group were lower than among a control group consisting of youth who did not suffer from ADHD. The study also noted that it was encouraging that only two per cent of those treated with stimulants went on to abuse stimulants or cocaine. **M.H.**

Pediatrics, v. 104(2):e20. Joseph Biederman, Pediatric Psychopharmacology Unit, Massachusetts General Hospital, Boston, Massachusetts.

Smoking trends among the deaf

Prelingually deafened adults are half as likely to smoke as adults who aren't hearing impaired. However postlingually deafened adults, those who lost their hearing after acquiring verbal language skills, smoke at about the same rate as the general population. As the deaf are more likely to have lower income and less education, which are associated with smoking, researchers at the University of Rochester suggest that sociocultural variables may have played a role in these differences. Prelingually deafened adults may have been protected from picking up the habit by: being exposed to less tobacco advertising, and by interacting among themselves and using sign language as their preferred method of communication. As postlingually deafened adults are more likely to communicate in English and socialize more with the general population, they're probably more likely to reflect overall societal trends. Researchers correlated age of onset of deafness with smoking behaviour by examining data from the National Health Interview Survey Hearing Supplement from 1990 and 1991. Explaining this discrepancy between the prelingual and postlingual deaf may go a long way toward reducing smoking in the general population. **C.H.**

American Annals of the Deaf, v. 144(1):44–50. S. Barnett et al., University of Rochester, New York.

Men may perform well but behave badly

Good behaviour during treatment is unrelated to parole failure or recidivism among adult sexual offenders. This was the finding of researchers at the Centre for Addiction and Mental Health. Results were based on a follow-up study of 283 sex offenders released from Warkworth Institution, a medium-security federal penitentiary in Cambellford, Ontario. However, men who scored higher in psychopathy (e.g., by being glib, manipulative, unempathic and deceptive) and who performed better in treatment (in terms of participation in group therapy sessions, quality of homework assignments and clinician ratings of motivation and overall change) did much worse than the rest of the sample. These men were almost six times as likely to commit a new serious offence (violent or sexual) after their release. Two explanations for this result were proposed. Men who are adept at being deceptive and manipulative may be better at figuring out what to say and how to get a good performance evaluation. Alternatively, these men may have learned skills in treatment, such as improved communication and assertiveness, that increased their risk of reoffending by facilitating greater access to potential victims. **C.H.**

Journal of Interpersonal Violence, v. 14:1235–1248. Michael Seto and Howard Barbaree, Centre for Addiction and Mental Health, Toronto.

Binge eating and drugs

Researchers at the Centre for Addiction and Mental Health found that binge eating is significantly related to substance use among both male and female adolescents. Using data from the 1997 Ontario Student Drug Use Survey, researchers categorized a sample of 1,031 girls and 888 boys as non-bingers, past bingers and non-compensating or compensating binge eaters (those trying to prevent weight gain by e.g., using laxatives or inducing vomiting). While more women than men reported ever entered into the activity as a means of losing weight; men, on the other hand, were as likely to be trying to gain weight as to keep from gaining weight. Binge eaters, especially those who compensated, were more likely to engage in heavier and more problematic drinking, as well as to use marijuana and other drugs. Though there were few gender differences in the relationship between binge eating and substance abuse, women were more likely to report compensating behaviours. Researchers hope that this information will translate into preventive substance abuse programs for students recognized as binge eaters. C.H.

International Journal of Eating Disorders, v. 26:245–260.

Helen E. Ross and Frank Ivis, Centre for Addiction and Mental Health, Toronto, Ontario.



The impact of child care and mother-child interactions

Children who regularly spend time in non-maternal care may exhibit "somewhat less positive" interactions with their mothers than those who spend little or no time in non-maternal care. In examining child care and mother-child interactions experienced by children at six, 15, 24 and 36 months, researchers of the U.S. National Institute of Child Health and Human Development (NICHD) Study of Early Child Care found, during a joint play procedure, that the less time children spent in non-maternal care, the better their interactions were with their mothers. This finding was based on analysis of data collected as part of a long-term follow-up study of child development. The results may indicate that increased hours in child care reduces the mother's familiarity with her child, resulting in mother and child being less "in tune." However, researchers found that education level is actually more predictive of maternal sensitivity than hours in care. They also found that the size of the link between hours and maternal sensitivity was similar to the size of the link between maternal depression or child temperament and maternal sensitivity. While setting (e.g., home, centre or relative's house) did not influence the results, quality of care did, showing that the higher the quality of the child care, the more harmonious the interactions between mother and child. The long-term impact of these modest effects has yet to be determined. C.H.

Developmental Psychology, v. 35(6):1399–1413. National Institute of Child Health and Human Development's Early Child Care Research Network, Washington, D.C.

Zoloft and CBT together benefit dysthymic

Until recently, there have been relatively few studies on the effectiveness of cognitive behaviour therapy in treating dysthymia, a chronic low-grade depression. However a recent study of 97 patients in Ottawa sought to evaluate the relative benefits of the antidepressant sertraline (Zoloft), CBT and a combination of the two in the treatment of dysthymia. The study found that while sertraline was an effective treatment for dysthymia, CBT appeared to be less effective, despite its past success in treating major depression. The results indicated that, while there was a pronounced improvement among those patients treated with sertraline, alone or in combination, the effect of CBT alone was not significantly greater than that of a placebo. However CBT did augment the effect of sertraline for some aspects of depression, such as individual coping and cognitive restructuring. M.H.

American Journal of Psychiatry, 1999; v. 156:1608–1617. Arun V. Ravindran, et al., Department of Psychiatry, University of Ottawa, Ottawa, Ontario.

Inhalant users start at age 13

Inhalant use has been found to have approximately the same prevalence among incarcerated youth as the general population (17.9 per cent as compared to 21 per cent). In a survey of 285 adolescents being held by the state's Department of Juvenile Justice, researchers at the University of Virginia sought information on types of products, prevalence by race and gender, and physical and psychological effects of inhaling, particularly in terms of depression. They discovered that the typical user of inhalants started at age 13, administered legally obtained substances through "huffing" (breathing fumes through the mouth), obtained the drug at home and may have suffered from depression and feelings of hopelessness. The five most common substances used were gasoline, freon, butane lighter fluid, glue and nitrous oxide. Researchers recommended that both more research be undertaken to fully explore the connection between inhalant use and mental health problems, and that primary substance abuse prevention programs begin before students reach adolescence. C.H.

American Journal of Drug and Alcohol Abuse, v. 25(4): 731–741. McGarvey, Elizabeth L. et al., Department of Psychiatric Medicine, University of Virginia, Charlottesville, Virginia.



Paintings on cigarette packs by Menno Krant

It's art that comes from the mind

BY DIANA BALLON

OUTSIDER ARTIST MENNO KRANT shirks from the idea of his life being altered by recognition in the art world. Five or six years ago, he was living out of his car, a beat-up 1992 white Plymouth, from which he would paint – in the middle of the night – in secluded places, using only the streetlights to illuminate his work.

Then one day he went into an antique dealer's and bought a little wooden horse. When the store owner came to collect his money, he saw Krant's paintings, and asked if he could sell some of his work at a flea market. The owner later bought some of his paintings to show a friend in New York, which led to his works being exhibited at the annual International Outsider Art Show there.

Today, Krant is internationally renowned, and his paintings are sold in seven countries. He also now owns his own home. Krant says he had to buy a house because he could no longer fit his works – which number in the thousands – in a car. He can now view his paintings hung from a distance, thus gaining a perspective he never had.

"I told my agent to find me the cheapest house in Toronto, and this is it," he says, gesturing around him. "The house cost \$100,000, and I put \$5,000 down." We're sitting drinking tea in the living room of a rather run-down house on a small side street in the seedy area of Sherbourne and Dundas. Besides the sofa, a coffee table and a television (blaring *Star Trek*), there is only Krant's work – literally rows of paintings stacked one in front of the other, and hovering over us, their subjects staring at us rather ominously.

The impression is eerie, dark and, well,

impressive. The subject of almost all Krant's works are what he describes as his "little characters" – people you see [on the bus or walking down the street], and wonder what they're thinking or doing.... Their eyes are giving you some kind of expression, some kind of personality look."

In most cases, that look is scared, stunned or surprised – perhaps not the sentiment you want reflected in a cosy breakfast room. Yet the honesty is mesmerizing. The lines are aggressive and strong, the impression like a TV cartoon. Directly in front of us hangs the painting of a character surrounded by a turquoise background, and chaos, "like an explosion.... It's like someone running from you and stopping and trying to tell you something," he explains.

While Krant says you could call the work Y2K, all his paintings are untitled. He'll give them nicknames, like the "Cat Group," referring to a series of about 10 cat paintings he recently completed, but he doesn't want to give his paintings names, because then he has to think about what they mean.

Painting is just "something I like doing," he says, "like watching TV or reading a book. The works were never intended for an audience." In fact, Krant says he avoids going to his own exhibits: "It's like singing in the shower, and all of a sudden you're on stage naked."

Being exposed was threatening to Krant. "For the first two years, I was trying to hide. But the more I hid, the more it backfired," Krant muses. At 49 years old, the native-born Dutchman looks about 30 and speaks with a soft voice that adds to his boyish quality.

"One day, a billionaire from Chicago and his wife flew here to look at my paintings. They were Beverly Hills-looking people. And when they arrived, the man said, 'Me and my wife were worried you wouldn't like us, and wouldn't sell to us,' and here I was, wondering what they would think of me. They left with 35 paintings, and paid the gallery \$100,000."

Krant's canvases sell for about \$6,000, where once they sold for about \$100. In the last year, he has painted about a thousand canvases, and even more than that number of works on discarded cigarette packs. (Krant is a chain smoker.) But he still doesn't have any money. "I give it away or spend it because I don't want it to change my life," he says.

Krant paints every day, usually until about 3:30 a.m. He's scared that if he doesn't keep painting, he'll stop.

Though he lives "outside" society's margins, Krant no more wants to be labelled as an outsider artist than he wants his paintings to be titled. To him, the term "outsider artist" "means nothing.... [Maybe] it's others deciding where to put you." He does contend, however, that outsider art is "art that comes from the mind." [But] you have to be good at it. You have to get to a point where your art is different and unique." When I ask, gingerly, if there's any association with mental illness, he says that he has "something, but not enough to get medical help."

Perhaps Krant's inner struggles with "something" are what lends his work its rawness, its darkness, and its acute sensitivity. ■

Menno Krant exhibits at Tableau Vivant Gallery, 917 Queen St. West, Toronto.

Spirituality and psychotherapy

Wrestling with life's bigger questions

BY CINDY MCGLYNN

MANY CANADIAN DOCTORS and therapists agree that people with mental health or addiction problems routinely wrestle with questions about the meaning of life, and the nature of suffering. They wonder about good and evil, guilt and forgiveness, where we come from, and where we go when we die. Because of the nature of these questions, some therapists believe that tapping into clients' spiritual lives can offer a powerful tool for processing their traumatic experiences. And possibly, for speeding up healing.

"We answer these questions in a variety of ways, through story and myth and belief systems that teach and enculturate us. Our belief systems provide symbols and rituals, which strengthen us to face our life journeys." And they fortify the part of us we call spirit or soul, says Maureen Soukoreff, manager of spiritual and religious care at the Centre for Addiction and Mental Health (CAMH).

Research studies have demonstrated that people who have a well-developed spiritual life can draw on that strength for healing. The presence of spiritual and religious caregivers in a health care facility shortens bed stay and brings spiritual comfort to people suffering illness or isolation, Soukoreff says.

The multifaith spiritual and religious services at the CAMH are made up of Christian, Jewish and Muslim staff, who offer counselling and support to staff, clients and family members from a variety of spiritual groups. The staff assist especially at births, comings-of-age, marriages and deaths, "and when trauma has created abrupt change in a person's sense of security," says Soukoreff. "At such a time, remembering one's religious and cultural tradition can lead to acceptance of the trials that surround human life."

In a country as diverse as Canada, it can be a real challenge to properly address spiritual issues. Different cultures and religions may each use a unique vocabulary. While spirituality as we understand it transcends ideology and ritual, it is also expressed through religion, culture and philosophy.

CAMH psychiatrist Dr. Sarah Danial says she's found issues surrounding spirituality to be relevant in about a third of her patients. "Sometimes it may come indirectly," says Danial, citing the example of a young woman



Detail from "God/Worship" by Sungil Chung

who was curious about Danial's use of the hijab, a scarf sometimes worn by Muslim women. As it turned out, the client had issues herself with expectations related to her own Catholic upbringing.

"I don't force the issue [of spirituality onto clients]," says Danial. "But a lot of times people have issues about their own meaning on earth; why they have an illness, or why they are having marital problems."

Increasingly, Dr. Danial says she is called upon to treat fellow Muslims, who feel she will better understand issues related to the religion. "I can think of a case in which there could be a lot of

misunderstanding. Muslims believe there are angels around you, watching you and recording your actions. If you don't accept that, you are not accepting one of the basic tenets of the religion. Now if I am a client, and I tell you that there are angels beside me, you may think I'm psychotic. You may misdiagnose my condition if you don't appreciate the religious context."

The potential for this kind of misunderstanding is not unique to Muslims. Rhonda Roffey, patient advocacy coordinator for the Ontario Federation of Indian Friendship Centres, recalls working on the front lines with homeless youth. Too often, she says, the spiritual visions and voices of aboriginals are misdiagnosed as schizophrenia. "I used to tell my aboriginal clients, 'Don't tell them that you hear anything or see anything,'" says Roffey. "I would say, 'It makes perfect

sense to me and I know what you're talking about. But just don't mention it.'"

That said, Dianne McKay, the Friendship Centre's alcohol and drug program developer and trainer, says spirituality is so essential to native culture, it is almost impossible to proceed without addressing it. "When it comes to healing, we look at the physical, mental, emotional and spiritual aspects. Those areas are not divided..."

In fact, McKay says sweat lodges are still used to cleanse the spirit and seek guidance: there's one at the Hagersville New Horizons addiction treatment centre in Ontario. And often, natives ask for traditional medicines while receiving western medical treatment.

Despite the need, Danial says spirituality is too often not addressed by therapists. "When we go through training to do psychiatric assessments there are few people who say we should always ask about religion. But it's part of an overall assessment that is usually overlooked in the rush of getting medical and psychiatric symptoms." Also, some may worry that a person's spirituality is off-limits because they come from a different religion. While observance can be helpful to a therapist, Danial says the therapist can still offer appropriate spiritual guidance and be of a different persuasion.

"Ultimately," says Danial "I really think the question is not about what religion a person subscribes to. It is 'How does their view of God or a higher power relate to their current problem?'" ■

Clergy are affordable – but trained?

Caregivers are not always medical professionals. Many people with mental health problems turn first to their clergy members. Clergy are accessible, affordable and are often seen as the most obvious place to turn. Unfortunately, according to American researcher J. Dillingham, clergy in general lack training in mental health problems.

Canadian religious leaders generally have at least a Bachelor's degree and about three to five years of training after that, according to Janet Somerville, general secretary of the Canadian Council of Churches in Toronto. This is not standard, however, and it varies from one religion to the next.

The Internet On-line therapy or addiction?

BY PAUL JAY

TECHNOLOGY HAS ALWAYS BEEN A double-edged sword; for all of the promise of any new innovation to improve our lives, it almost always comes with its dangers and difficulties. Such is the case with the Internet, and nowhere is this more true than with its impact on mental health.

The latest phenomenon to attract the attention of the mental health community is "Internet addiction." Popularized by American psychologist Dr. Kimberly S. Young, Internet addiction disorder (IAD) is the name given to excessive participation and thought directed towards any number of Internet functions: from day trading to on-line shopping, from chat rooms to simply surfing the Web for long periods. Young believes people with pre-existing addictions or mental health problems are at greater risk of developing IAD.

"In my original study, 52 per cent suffered from chemical dependency or other impulse control disorders," she says. Those who suffer from a chemical dependency substitute their substance abuse with Internet binges, and see this as healthy compulsive behaviour, because there is no medical risk, says Young.

Young's original study results were accumulated from a survey she conducted through an Internet mailing list. Of the 496 respondents, she concluded that 396 were addicted in some way. Questions included: "How often do you lose sleep due to late night log-ins?" and "How often do you block out disturbing thoughts with thoughts of the Internet?"

She has since turned her research into a best-selling book, *Caught in the Net: How to Recognize the Signs of Internet Addiction*, and has organized a Web site to act as an information centre for IAD – The Center for On-line Addiction. And others have followed. The University of Maryland at College Park offers a counselling group for students suffering from IAD, and McLean Hospital in Massachusetts has launched the Computer Addiction Service. The disorder reached its media peak in 1997 when a Cincinnati woman was charged with child neglect after ignoring her children for more than 12 hours per day while she surfed the Internet.

But not everyone sees IAD as a true addiction. Some such as Dr. Ivan Goldberg

believe IAD does not qualify as an addiction in the clinical sense, as might heroin addiction or alcoholism, but is instead more of a compulsive behavior disorder. Still others dismiss the studies of IAD supporters as flimsy and reject that any such disorder has been proven to exist.

Young says that IAD's strongest proponents are the ones dealing with it on a daily basis. "It has been accepted by practitioners and therapists in the field who have seen the problem first hand in their clinical practice," says Young. "Academicians [are the ones who] still debate the term addiction and its correct application. The long-standing issue is what can and cannot be classified as an addiction-substance dependence versus a behavioural addiction."

But some mental health experts feel that little has been learned from the studies conducted thus far. "The same qualities found in Internet addicts could equally be applied to someone who watches television or reads books," says Dr. John Grohol, past president of The International Society for Mental Health On-line (ISMHO). "The research has been very biased and exploratory in nature. For example, how much time does someone need to spend on the Internet to be considered an addict? If you can't even agree on the basic tenets of the disorder, then how can you begin to classify it?"

Perhaps more importantly, Grohol feels the Internet can be a positive tool for the mental health community. In 1997, he and other psychologists got together at the annual convention of the American Psychological Association and decided that a new organization

was needed to discuss the ways in which this technology could be helpful. ISMHO has since become a leader in discussions concerning the benefits of on-line communication for the delivery of psychotherapeutic services, or e-therapy.

E-therapy has excited many in the mental health community because it offers another modality to help people resolve personal issues. As Grohol wrote in a paper for ISMHO, e-therapy is not psychotherapy or counselling, "[s]ince it does not presume to diagnose or treat mental or medical disorders, and because it does not limit who may be appropriate to provide e-therapy services...." It is, however, an effective way to coach someone and help address their specific concerns, he says.

One of the advantages, says Grohol, is the time lag between e-mail correspondence. "There is more of a thought process, more chance to interact and react and get involved in complex interaction," he says.

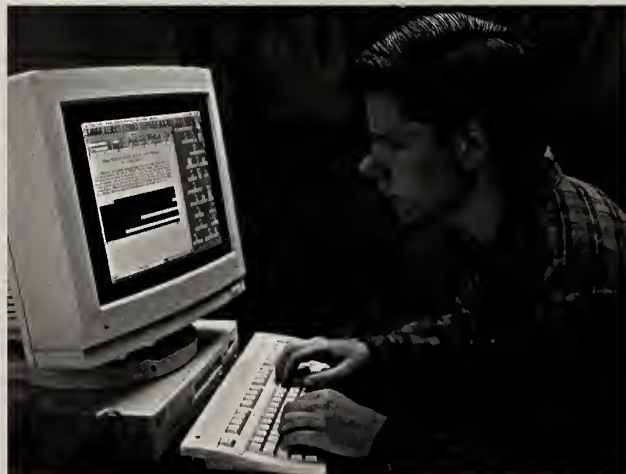
For some clients, this is more relaxing than a one-on-one session where they might be required to think on their feet and come up with immediate responses to questions, he says. And while the audience for e-therapy can be anyone, it has potential advantages for the house-bound, agoraphobic or those with speech difficulties. Even Young recognizes e-therapy's potential value, saying that "it is really very effective."

Yet despite her belief that the tools and applications of the Internet may be harnessed to help deal with IAD, Young thinks it remains an imperfect medium and one in need of changes. The biggest problem in her mind is "the legal implications of anonymity leading to deviant and criminal conduct on-line."

Whether you fear the negative effects of IAD or dispute the results of e-therapy, we can all at least agree that, as another venue for information on mental health, the Internet remains a valuable resource. ■

The Centre for On-line Addiction can be reached at <www.netaddiction.com>.

The International Society for Mental Health On-line can be reached at <www.ismho.org>.

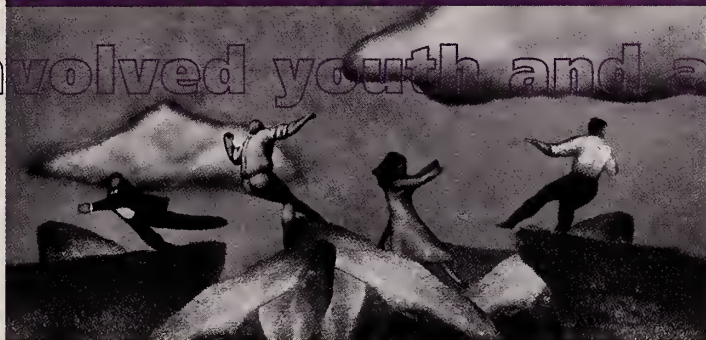


[falling through the cracks]

Street-involved youth and addictions

two perspectives

BY CINDY McGLYNN



TREATING ADOLESCENTS WITH SUBSTANCE ABUSE PROBLEMS has always been a tough job. Not quite adults and no longer kids, teens need special attention that recognizes the distinct emotional and social world in which they live.

Youth's addiction problems are becoming even more complex, according to Chris Higgins, executive director of the Ontario Federation of Community Mental Health and Addiction Programs. Adolescents are often addicted to multiple substances. Frequently homeless or living in poverty, young people may be dealing with the hazards of street life: they may be involved in criminal activity and exposing themselves to dangerous infections.

The two programs profiled here take distinct approaches to the problem. Montreal's Dans La Rue focuses on harm reduction and helps give street youth the resources to help themselves. The University of Miami's Center for Treatment Research on Adolescent Drug Abuse does intensive, family-based therapy for "deep end" kids: many are multiple substance abusers with criminal histories, all have mental health problems.

In both programs, dedicated case workers try to overcome the gaps in services which Russ Larocque, provincial chair of the Ontario Youth Managers Group (an umbrella group dealing with youth addiction services) says is the biggest problem facing youth addiction workers today.

School boards, addiction services and community centres partner up in an ad hoc way to help fill the gaps, "which is vital, because I don't remember the last time I treated a kid who just had an addiction problem," says Larocque.

But these ad hoc partnerships are hard-pressed to completely meet these kids' complex needs. It's been eight years since youth addiction services in Ontario have received a funding increase, and there are only 50 residential treatment beds for adolescents in Ontario. "We may not get any more money and gaps are there and we need to take a more innovative approach ourselves, because frankly some of these kids are dying," Larocque says.

Dans La Rue

Every day, as many as 250 people visit Dans La Rue day centre in Montreal. All of Dans La Rue's clients are under 25. And all of the services they receive at Dans La Rue have one aim – to prevent the harm associated with street life and help kids get off the street for good. The centre's nurse, Micky Antoniazzi, sees all types: kids who call the street home, young mothers struggling to make ends meet on social assistance, and gangs of transient youth.

There is at least one thing most of them have in common: drug use, and often drug addiction. "I would say that probably 90 per cent of them use drugs," says Antoniazzi. "We did a loose census of kids who are injection-drug addicted and it's about 50 per cent. We get the same numbers from public health program studies."

Dans La Rue assesses and refers clients to addiction treatment programs. They offer punctual treatment to kids in need, including medicinal

treatment for those suffering from heroin withdrawal. But their main focus is to work towards prevention by offering resources for youth to get back on their feet.

From where Antoniazzi sits, the obstacles to recovery are varied. Some kids are in denial about their need for help. Some need a huge variety of services. Antoniazzi says it's not unusual for someone to need a place to live, drug rehabilitation, remedial reading courses, family counselling and medical attention for serious problems like hepatitis.

Dans La Rue solves some problems. They provide a steady mailing address, for example, so kids can apply for and receive Medicare. But they can't solve the waiting lists at agencies where they refer the youth. The paper trail to services is long, and kids are getting lost along the way.

CTRADA

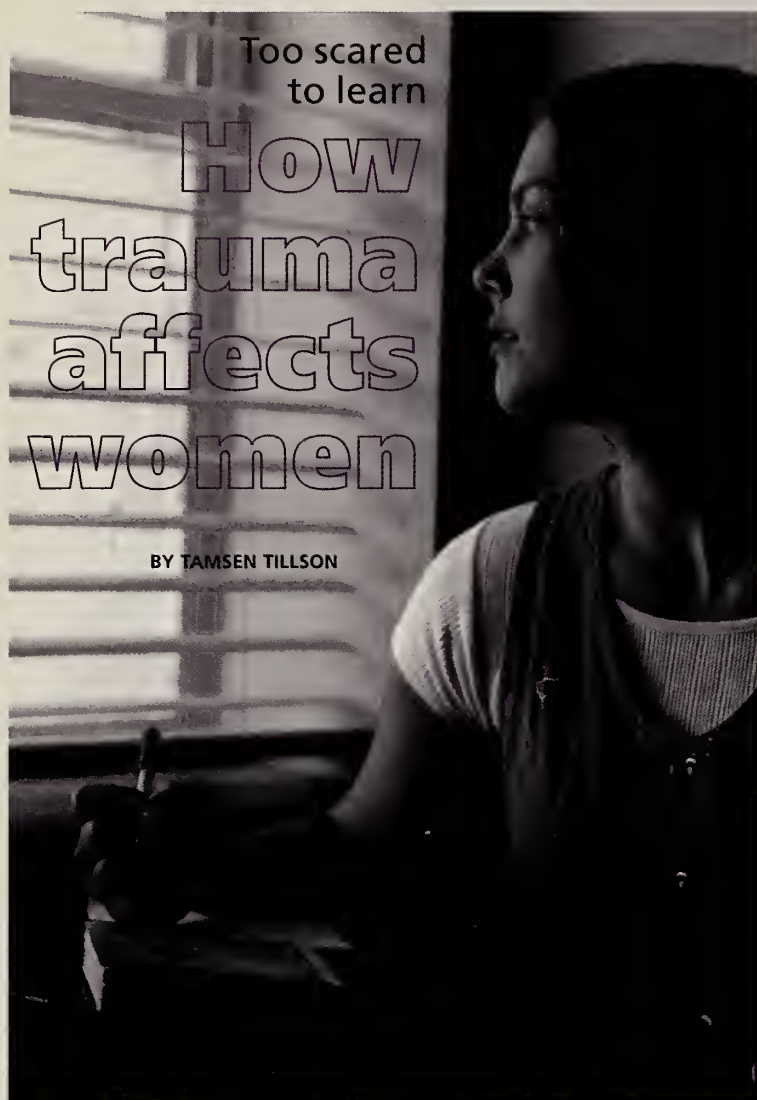
Researchers and therapists at the University of Miami's Center for Treatment Research on Adolescent Drug Abuse (CTRADA) are studying and treating groups of young people with at least one addiction and a mental health disorder. They're testing an intensive family-based therapy model where, for six to eight months, teens and their families devote sometimes dozens of hours a week to intensive therapy.

The project's senior family therapist, Tanya Quille, calls her clients (who are aged 14 to 17) "deep end" kids. Many have had multiple arrests. Some are gang-involved. All are drug users, often with more than one addiction. "Currently all of our clients have marijuana dependence. Some also have cocaine abuse problems. All of them also have conduct disorder. Some have depressive disorder and some have attention deficit disorder."

Treating the teenagers is very different from treating adults, stresses Quille. Adolescence is a time when young people traditionally seek independence. But it's crucial to therapy that they learn that family members can depend on one another. That's one reason CTRADA favours home-based treatment involving therapy with the whole family. "In the past, residential treatment was always considered the gold standard," says Quille. But when juveniles leave, "they've got to go back to their homes, their schools and friends and communities. If you haven't made advancements in those areas, there is real danger of relapse. Our [approach] ... is to do very intensive home-based treatment and interact with all the systems that our kids interact with."

The program aims for abstinence, but Quille stresses that no one is expelled for relapse, or occasional substance use. Therapists will even visit clients in jail or detention to keep the therapy going.

Perhaps the biggest challenge of all, Quille says, is to give clients a reason to believe the therapy is for them, and not just to please their family or the system. "Engaging these kids is the primary job of the therapist. The adolescent has to be shown some kind of health trajectory for the long run. They have to ask, 'Where is my life going?' 'What is my life going to look like?' ... We ask them to let us help them have a future." ■



LILLIAN WAS STRUGGLING TO MAINTAIN SOME NORMALCY IN her life while in the process of leaving her violent husband. Though she struggled to keep up with her adult education math class, she eventually concluded that math was just not her strong point. A couple of years later, after the storm in her life had settled down, she came across her math text. Flipping through, she found it surprisingly straightforward. "[W]hat a difference it would have made if someone had explained to her at the time that it is often hard to think when you are dealing with a crisis," writes Jenny Horsman of the incident.

Horsman is a community-based researcher and educator who maintains that Lillian's experience is not unique, and that violence and trauma – past or present – affect learning. "It's not like teachers haven't known adults who have been dealing with violence," Horsman says, "but it's unspoken. They hear the stories around the edges."

This is exactly how Horsman herself came to the subject. About a decade ago in the course of doing a research study of women's experience of literacy and illiteracy in rural Nova Scotia, almost all of her interviewees steered the conversation to violence they had experienced in their lives. "At the time my reaction was, 'That's not what I want to know about,'" she confesses, "but more and more I began seeing that their experience of violence was a central factor in their lives. Then I began to question how the experience of violence as kids was part of the picture that led to their illiteracy."

The first thing she found in exploring her theory was that it had been given short shrift in academic circles. While there is plenty of material about how trauma affects us psychologically, there is very little on how it affects learning. Literature that does explore the link does so exclusively in the area of brain research. For instance, the late Dr. Hans Selye of Montreal found that a chemical known as cortico-steroid, released in the brain in times of stress, becomes toxic to neurons in the hippocampus if released in too high quantities. (The hippocampus is both the basis of spatial learning and a temporary storage area for the formation of memories.) When the hippocampus was removed from epilepsy patients in studies by Brenda Milner in the 1960s, "they couldn't make any new memories," notes Dr. John Roder, a learning and memory expert at Mt. Sinai Hospital in Toronto. Though trauma is not specifically his area of expertise, Roder says it makes sense that the same effect on memory could occur in those who experience violence in the home.

To explore how trauma affects women's literacy, Horsman travelled across Canada and spoke to about 150 people – mostly women literacy workers, learners, therapists and counsellors. Her goal was to present a primary sketch of the effect of trauma (whether the result of sexual abuse, physical or emotional violence or neglect), and what might be done to help. Horsman's recently published book, *Too Scared to Learn: Women, Violence and Education*, is the result – a paperback manifesto calling attention to a silent and ubiquitous presence in many classrooms.

Horsman found that those who live with trauma – past or present – tend to react in an educational setting by acting out, spacing out (disassociating) or escaping into the mind. In the first two examples, the individual often performs poorly in school, drops out or squeaks through, often without learning to read and write well.

For those returning to school as adults, many inadvertently sabotage their education, for instance, they may make an initial, valiant effort to learn, and then become discouraged when it doesn't lead to instant success. "I was told that the idea of daily effort gradually leading to change was often unusual to survivors," Horsman writes. "Those who grew up in violent and chaotic homes may have had little experience of seeing regular effort lead to results." They're terrified of making mistakes, and can easily lose hope and quit. Some in current abusive situations can't attend classes due to physical injury, or are unable to focus on their studies because all their energy is taken up by life-or-death situations at home. The school setting may also trigger negative feelings that affect their ability to perform.

"Literacy workers are very familiar with the idea that many learners have difficulty paying attention for any stretch of time," Horsman writes, "and many often appear to be daydreaming or bored. That discourse can lead some literacy workers to identify those who are not paying attention as not serious students, or not motivated."

Others might attribute students' difficulties to learning or intellectual disabilities, fetal alcohol syndrome or attention deficit disorders. "Still others might judge their own teaching as not interesting enough. ... Whatever the judgement as to the cause, the result is likely to be frustration for workers and learners alike," writes Horsman.

As ground down as teachers can become not knowing what the problem is, it can be just as stressful when they do. Sometimes students will come to a teacher, saying, "Have you got a minute?" which then "turns out to be an opening of some horrendous story," she says, "and teachers feel completely inadequate."

That's because teachers teach and counsellors counsel. And perhaps our current educational system needs to undergo changes that enable teachers to integrate such seemingly diverse fields. ■

WHO targets mental illness in developing nations

BY ANGELA PIRISI

IN A SMALL COUNTRY OF 60,000 IN THE SOUTH PACIFIC, YOUNG men are committing suicide in soaring numbers. Given that suicide in the Marshall Islands was virtually unheard of only a generation ago, the increase is startling. Experts attribute soaring rates to rapid social and cultural changes that have led to a breakdown of the traditional family structure, as well as to isolation and unemployment.

Research in the developing world indicates that suicide is a staggering problem that far outreaches physical, life-threatening diseases. Recent figures from a U.K. study led by researchers at Oxford and Colombo Universities found that in Sri Lanka, 41 per cent of intensive care beds in a north central hospital were occupied by people who had attempted suicide by poisoning themselves. By contrast, nine per cent of beds were filled by patients with heart-related complaints.

Despite the vast gains in treatment of physical health problems over the decades, mental health problems have suffered from neglect. This is especially true in developing nations, where the focus has been on physical health and mental illness has been only marginally reflected in mortality figures. In such countries, mental health problems are often compounded by the effects of violence, poverty, displacement and stigmatization. According to the World Health Report 1999 presented at the 52nd World Health Assembly in Geneva last May, neuropsychiatric disorders accounted for 11.5 per cent of the global burden of disease in 1998. Mental illness also comprised four of the top 10 leading causes of disease burden in adults aged 15 to 44.

Poor socioeconomic conditions are admittedly a catalyst for mental illness among developing nations. Dr. Arthur Kleinman, chair of Harvard University's Department of Social Medicine, and an expert on international mental health, says that mental health and social problems tend to cluster to the point that they are inseparable from one another. He cites results of the U.S. National Co-morbidity Survey, which found that, as socioeconomic status goes down, the prevalence of psychopathology increases, and vice versa.

In response to the problems in developing countries, the World Health Organization (WHO) initiated an international action program called Nations for Mental Health to target disabling mental, neurological and behavioural problems in underserved populations. So far, the international project has embraced 16 countries, among them Argentina, Belize, Bhutan, China, Egypt, Ghana, the Marshall Islands, Mongolia, Mozambique, South Africa, Sri Lanka and Yemen.

The timing seemed ideal, asserts project leader, Dr. Benedetto Saraceno. "[W]ith recent advances in psychiatric medications and specialized forms of psychosocial interventions, the potential for improvement is greater than at any time in history," he writes in a recent issue of the WHO's newsletter, *World Health*.

Not surprisingly, suicide in the Marshall Islands has been one of the WHO's targeted problems. There, the WHO has tried to educate the islands' citizens, including mental health workers and the families of victims, about the causes of suicide. The WHO has built an awareness campaign and provided training in preventive and care strategies for mental health care workers. This includes three educational videos on suicide, made culturally relevant by including taped interviews with traditional chiefs, church ministers, government officials and other community



leaders articulating their views and advice on suicide. As well, newspaper articles in local papers have focused on suicide

prevention, while a radio talk show has made suicide the topic of weekly discussion. A national conference on suicide is also being organized.

Cultural context influences mental health problems. In Ghana, for instance, low awareness and high stigmatization of mental illness means that many patients lack access to proper assessment, and to family and community support. There staff members, volunteers, as well as patients' families have had to be taught to alter their perception of psychiatric patients, whom they once described as "aggressive," "dirty," "unproductive" members of society, and whom they believed to be touched by sorcery. Similarly in the Marshall Islands, the public perception is that suicide is caused by demons or evil forces, romantic disputes or family problems. Those with mental illnesses are further ostracized by a culture that often views mental health problems as a blight on a family: people with mental illnesses are frequently hidden, abandoned in psychiatric hospitals or sent into the care of herbalists or traditional healers.

Saraceno suggests that tackling mental illness is really a matter of understanding the place where it occurs and its human resources, then targeting the disease. "The real difference between countries is not the treatment per se but rather the framework within which the treatment is delivered, relative to the mental health policy and the service organization of a given country," he says. Given the lack of specialist services, most treatment of mental health disorders ends up being delivered by primary health care workers. To redress this, community psychiatric nurses, doctors, medical assistants and public health nurses in Ghana have been specially trained by WHO workers in how to be sensitive to the needs of people with psychosis and epilepsy, the two problems targeted by the WHO in that country. As a result of widespread education, the number of mentally ill treated in one district quadrupled over a few months.

The countries involved in Nations for Mental Health are known as demonstration projects because they will serve as models for larger scale implementation. "Of course not all projects can be replicable on a larger scale," says Saraceno. "Obviously what is positive in a very small country will not necessarily work in a macro country." But as Kleinman suggests, concentrated, smaller scale efforts are the backbone of more expansive efforts and results. ■

Q & A

Common questions about 'falling through the cracks'

What do you mean by falling through the cracks?

In the context of the mental health and addiction systems, we are referring to policies and services that are failing to address the needs of certain groups of people. These may be people with dual or concurrent disorders, or people with multiple problems whose concerns are not adequately being met. It may also refer to people within certain age groups, such as youth and elderly, whose needs are not being met by pre-existing services. Gaps often occur when systems haven't learned how to work together, and when there are shared jurisdictions and confusion about who is to assume responsibility.

Who are the largest group with mental health or addiction problems to be falling through the cracks?

One in five will suffer from some form of mental illness. However an estimated 75 per cent won't receive services in the preceding year, according to the *Ontario Mental Health Survey (1990)*. Thus a large segment of the general population are not receiving the psychiatric services they need. Within the general population, people with concurrent disorders are one of the most underserved groups: statistics on people with persistent mental health problems who also have an addiction range anywhere from 30 to 75 per cent. (U.S. studies indicate that the 75 per cent tend to be forensic clients.) Yet there have been relatively few strategies – and no policy – in Ontario to bring the two together. While in the early 1990s, \$2.5 million was set aside by the Ontario Ministry of Health to facilitate co-operation between mental health and addiction agencies, this money never got spent because of cutbacks. Only now are people starting to close the gaps between these two solitudes by developing co-ordinated strategies in pursuit of integrated care.

Where are other gaps in the addiction and mental health systems?

There are critical gaps in services at both ends of the age spectrum: with youth and the elderly. While children to the age of 18 receive services from the Ministry of Community and Social Services, care for youth aged 16 to 24 falls under the mandate of the Ministry of Health. Unfortunately, adolescents may end up receiving services based on their age, though *not* necessarily suited to their



needs. For instance, our children's health care system tends to address mental health problems, but not addictions. Youth thus end up entering the adult system, with often very severe, poly-drug addictions that have gone untreated for several years. Abuse of multiple substances is worsened by the prevalence of other psychosocial problems, such as homelessness, violence, prostitution and physical health problems, such as hepatitis C and HIV. As well, many youth suffer from depression, anxiety, isolation and a sense of inadequacy.

Seniors are also a neglected group. There are not enough geriatric psychiatrists or geriatric psychiatry teams to respond to their mental health problems, and not enough services to treat older persons in the community. Older persons may suffer from physical health problems, grief over friends or partners dying, and shame associated with their mental health or addiction problem. While the elderly are seldom addicted to street drugs, they may be affected by interactions between alcohol and prescription or even over-the-counter drugs. Problems such as alcohol misuse become more difficult to identify in retired people, as may other signs associated with aging, such as poor memory, falls, depression and isolation.

Our treatment of aboriginals is also inadequate. Some would argue that Canada is at "third world standards" in terms of offering ethnoracial services. As Dr. Rachel Jenkins of the World Health Organization said at the 1999 International Congress on Law and Mental Health: if instead of talking about health care, we talked about physical and mental health care, it would be harder to ignore mental health services.

As well, people with dual disorders (individuals with developmental disabilities and a co-morbid psychiatric problem) are falling through the cracks. Many make frequent and unnecessary visits to emergency rooms and end up admitted to hospital, due to lack of co-ordination of services and failure to understand these people's needs. This perpetuates a series of crises for the client, and a revolving door syndrome for the system.

What is being done, or has been done, to fill the gaps?

While a minimal amount can be done within organizations, a health policy could be developed

to not only recognize gaps in services, but also allocate additional monies to provide *more* services. (The CMHA Ontario Division has said that about \$80 million will need to be invested to create significant capacity in both addiction and mental health systems.) Mental health and addiction services need to be provided within a context of community supports, including housing, leisure and employment, that help keep those with serious ongoing problems living in caring communities.

To expand services to people with concurrent disorders, twinning programs could be informally developed between mental health and addiction agencies. Assertive community treatment (ACT) could continue to include addiction or concurrent disorder specialists on its teams. And we could follow the example of the United States, where people with concurrent disorders are treated through an integrated, community-based approach.

Forensic services in psychiatric hospitals are making concerted efforts to provide mental health and addiction services, while court diversion programs for low risk offenders are helping to link people with the services they need – whether this be housing, legal aid or other case management. In Toronto, the courts offer diversion programs. A range of mental health and addiction services could also be offered within the correctional system.

In terms of youth with addictions, much is already being done to offer innovative services that are linked with pre-existing services in schools, health care and mental health agencies in the community. This involves going out to reach youth where they are, developing a therapeutic relationship with them, and engaging them using a client-centred treatment approach.

DIANA BALLON

Sources: Steve Lurie, executive director, CMHA Metro Toronto Branch; Chris Higgins, executive director, Ontario Federation of Community Mental Health and Addiction Programs; Wayne Skinner, clinical director, Concurrent Disorders Program, CAMH; Russ Larocque, program supervisor, Family Counselling Centre: Alternatives for Youth, Sault Ste. Marie; Jean Byers, clinical director, Geriatric Psychiatry Program, CAMH; Margaret Flower, service manager, OPUS 55, CAMH.

The Living Museum

IF BEING "CURED" OF MENTAL ILLNESS MEANS David Halford would also lose his creativity, he says he'd have to choose mental illness.

A patient at Creedmoor Psychiatric Center in Queens, New York, David is one of several artists who creates inspired artwork at the Living Museum, a 40,000 sq. ft. art studio and gallery housed in a former dining hall on the Center's grounds.

In her film, *The Living Museum*, director Jessica Yu has unsentimentally yet tenderly portrayed the work, and by extension the illnesses, of David and other Creedmoor patients. Following an overview of the museum's history and philosophy, the film introduces the members of its community. We learn first of Issa Ibrahim. Talented and articulate, Issa currently lives in a forensic unit at Creedmoor following a run-in with the law. He builds installations with TV sets and toilets, paints murals and sculpts larger-than-life human forms with wire. He is determined to make a go of his art when he gets out.

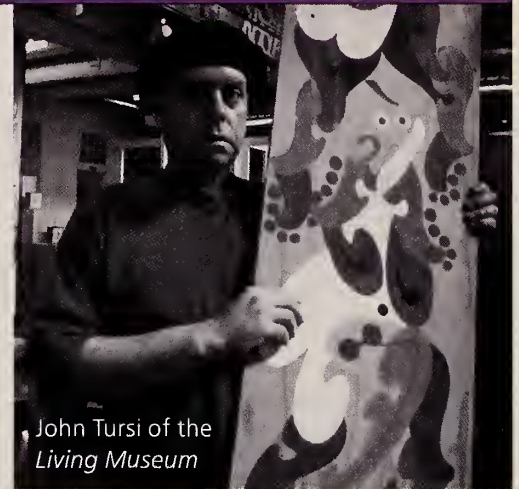
Then there's John Tursi, a gregarious man who believes he "owns the state." John is effu-

sive about his work. His drawings have a playful, almost cartoon-like spirit to them, and they hum with a sense of balance and vibrancy.

Other artists featured include Helen, who, along with John, is invited to exhibit her Zen-inspired panels of colourful lines in a Manhattan gallery, and Eileen, whose frequent outbursts of shrieking, so prevalent on the wards, are all but gone when she is making or discussing art.

The Living Museum is run by Dr. Janos Marton, a psychologist and artist, who co-founded the museum, along with his friend, the late artist Bolek Greczynski. Together, they envisioned a space where people diagnosed with mental illness could be accepted as friends and fellow artists, and where patients could evolve their self-definition from being "crazy" to being artists who happen to have a psychiatric diagnosis. Says Marton: "Mental illness and art are a natural combination. People who have a mental illness are extremely blessed with artistic creativity."

A visit to the museum reveals it to be as unconventional, supportive and inspiring as is portrayed in the film. For this, independent filmmaker Yu is to be praised. Her experience



John Tursi of the Living Museum

of making the film led her to believe that the making of art by people with mental illness was not necessarily a therapy or treatment modality for patients but "a way to find some meaning and beauty in what seems like the most traumatic and terrible experiences." The film offers viewers a glimpse into this beauty.

LISA SCHMIDT is a writer, editor and graphic artist. She is the internal communications co-ordinator at the Centre for Addiction and Mental Health.

The Living Museum, 1999, Home Box Office, 81 minutes, 16 mm, USA.

Crossing the Border describes the science of outreach

CROSSING THE BORDER BY MICHAEL Rowe clearly conveys why most white, middle-class professionals will never become homeless. For despite the perception that most of us could be "but a pay cheque away" from homelessness, homelessness requires being vulnerable in a variety of ways – through poverty, estrangement from family and friends, lack of education, loss of a job, physical or mental illness and substance abuse. Combined with "bad luck," homelessness is a risk that an observer can actually predict.

A critical piece of Michael Rowe's book explores the predictability of homelessness. The role of outreach to homeless people quickly loses its magical and ephemeral qualities and becomes instead a conscious, planned response to a predicament. Hence, outreach itself becomes more of a science than an art. Rowe's pragmatic examination dispels myths about people who are homeless and the experts who help them.

Crossing the Border could command a wide audience of professional mental health care workers, sociologists, anthropologists, bureau-

crats, advocates and policy-makers. As a program developer, a key interest for me is Rowe's cogent depiction of how a relationship develops between "outreach worker" and "homeless person."

He describes how the initial stage for an outreach worker is to recognize that homeless people live without houses but that they carry within them an internal sense of home. A proficient outreach worker will show respect for this internalization by using a cautious, considerate, non-intrusive approach. The outreach worker will also appreciate that homeless people's acceptance of housing (e.g., a room or an apartment) requires the subsequent acceptance of imposed social isolation. For many individuals, this trade-off is too risky.

Loneliness and isolation are repeatedly cited by homeless people and outreach workers as problems often without resolution.

Rowe discusses the "politicization" of the empathic outreach worker. Because the needs of homeless people are wide and deep, workers feel a special urgency to break down the personal, professional and institutional bound-

aries that are obstacles to solving the problems of homelessness. Outreach work clarifies the values and beliefs of its workers. It motivates them to challenge and work with passion and a sense of mission. When this is combined with clinical technique and expertise, workers become advocates addressing systemic issues.

A compelling theme in Rowe's book is the institutional ambivalence to serving homeless clients – an ambivalence that is often frustrating and contributes to the outreach team's sense of urgency. The outreach worker becomes both a liaison and educator, attempting to persuade the institution to respond to a marginalized clientele while working in uncharted territory with challenging clients.

For those who take on the challenge, Rowe clearly demonstrates how great the satisfaction and the experience can be.

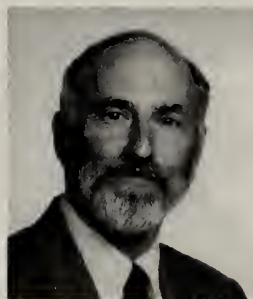
CYNTHIA KARLTON is the former manager of the Shared Care Clinical Outreach Program at the Centre for Addiction and Mental Health.

Crossing the Border: Encounters Between Homeless People and Outreach Workers, Michael Rowe, University of California Press, Berkeley, 1999, 193 pp, \$27.95.

The Last Word

Electroconvulsive therapy:

same old treatment,
same old results



BY DR. LEE COLEMAN

Editorials do not necessarily reflect the views of the CAMH. We welcome submissions from our readers. For information, contact: The Editor
The Journal of Addiction and Mental Health
33 Russell St., Toronto, Ontario M5S 2S1
tel.: (416) 595-6714
e-mail: <journal@camh.net>

IN THE LAST ISSUE OF *THE JOURNAL*, DR. VIVEK KUSUMAKAR presented the same old arguments for using electroconvulsive therapy (ECT). While he claims that ECT is beneficial, I would argue that it is barbaric.

Dr. Kusumakar begins by saying that ECT has “come a long way” simply because anesthesia, muscle relaxants and oxygen are now used, and because patients are closely monitored. Yet none of these things protects the brain from the potentially damaging effects of electricity. An electric shock is still being administered to the temporal lobes and hippocampus, the parts of the brain most involved in memory formation and storage.

Next, Dr. Kusumakar asks readers to consider ECT as just another medical treatment, pointing out that many surgical procedures could just as easily be described as gruesome. But while surgery is generally performed with patients’ consent, ECT is routinely used when the doctor and the family decide it is appropriate, not because patients want it.

Many ECT proponents argue that current consent procedures all but outlaw involuntary ECT, and that statistics show only a tiny percentage of patients receiving ECT who have refused the treatment. Such figures do not, however, account for the fact that most ECT candidates are inpatients, are not free to leave the hospital – even if ostensibly “voluntary” patients – and are not truly free to refuse treatment. If they do try to refuse treatment, they could then be placed on involuntary status, and legal procedures instituted to allow involuntary use of the treatment. Under such pressure, all but a tiny percentage of patients go along with what the doctor wants and sign a consent form.

Dr. Kusumakar also argues that critics of ECT claim it is used to punish, exploit or control people who are different. Most critics of ECT – whether former patients, journalists, physicians, neuroscientists or simply concerned citizens – have never uttered such shallow criticisms. Rather, they oppose the treatment as short-sighted, dangerous and routinely given without fully informed consent.

Dr. Kusumakar raises the issue of using ECT when there is “a perceived imminent danger to a patient.” Some patients, in other words, will kill themselves if ECT is not administered. That could happen, but proponents never seem to ask the parallel question: do any patients commit suicide *because* of ECT? As an expert witness in wrongful death lawsuits resulting from suicides, I have reviewed several examples in which the suicide appeared to result from the patient’s fear of forced ECT. In each case, the person had received ECT, was profoundly discouraged by the treatment’s long-term impact on memory and learning ability, and was later being pressured to receive the treatment once again. With an already severely depressed patient, it is dangerous to try to impose ECT.

The last thing we should do is to administer treatment that terrifies people, creating a situation in which persons desperately in need of help come to fear the very professionals who could help.

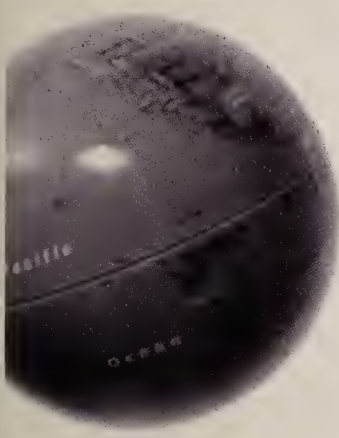
Dr. Kusumakar claims that there is “scientific evidence” for the efficacy of ECT. Yet “efficacy” gets interpreted as patients becoming easier to manage: they stop crying, stop talking about suicide and begin to eat. Their symptoms are temporarily suppressed through the induction of an acute brain syndrome (involving such symptoms as confusion, disorientation and amnesia) that are seen in the acute recovery phase following a brain injury. Yet nothing is done to deal with the source of the problem. Patients treated with ECT do indeed change, and very rapidly, just like anyone would if hit over the head with a blackjack or struck by the windshield of a car. ECT doesn’t actually “treat” anything; it merely sweeps patients’ distress, temporarily, under the rug. The confusion, memory loss and learning deficits induced by the treatment are *not side-effects: they are how the treatment works*. This is why every attempt to reduce so-called side-effects – by unilateral treatment, or altering the way electricity is delivered – inevitably leads to a corresponding reduction in the effectiveness of the treatment. As a result, ECT continues to be most often given bilaterally. Regardless of how ECT is modified, there is no way to get the desired result without the undesired result.

I recommend that skeptics briefly review the features of acutely brain-injured patients, as the clinical picture of ECT recipients is exactly the same. If these skeptics still claim to not understand how ECT works, then I could only surmise that they are uncomfortable acknowledging ECT as brain damage. Because the evidence stands: both ECT recipients and brain injury patients suffer anterograde amnesia (loss of memory for events before the injury), retrograde amnesia (loss of memory for events after), and sometimes long-lasting difficulties in retaining new information. As far back as 1983, Squires and Slater presented data in the *British Journal of Psychiatry* demonstrating that anterograde amnesia and long-term learning deficits experienced after ECT fit with well-established patterns known to result from brain trauma.

The most critical decision, whether treatment is appropriate for a particular patient, should be made by the patient and never by the doctor. Were patients informed that long-term memory and intellectual deficits are known risks, and were patients truly free from any coercion regarding the granting or withholding of consent, ECT would rapidly disappear. That would be a step forward. ■

Dr. Coleman practices psychiatry in Berkeley, California. His latest book, co-authored with attorney Patrick Clancy, is Has A Child Been Molested?

Conferences



CANADA

Advance Care Planning:

Ethics, Policy and Procedure

February 25, Toronto, Ontario.
Contact: Conference Services,
Toronto Rehabilitation Institute,
tel (416) 597-4494 ext. 3693,
e-mail <conferences@torontorehab.
on.ca>.

Women and Psychosis

March 3, Toronto, Ontario.
Contact: Cynthia Gomes,
tel (416) 535-8501 ext. 4582,
fax (416) 979-6981,
e-mail <cynthia_gomes@camh.net>.

Acquired Brain Injury and Addiction

March 3-4, Toronto, Ontario.
Contact: Dennis James,
tel (416) 535-8501 ext. 6066.

Preserving Human Dignity:

13th Annual Alzheimer Symposium

March 31, Toronto, Ontario.
Contact: Conference Services,
Toronto Rehabilitation Institute,
tel (416) 597-3422 ext. 3693,
e-mail <conferences@torontorehab.
on.ca>.

First Conference on Healing Sexual Exploitation and Prostitution

May 4-6, Edmonton, Alberta.
Contact: (780) 497-5188,
e-mail <a2a2000@gmcc.ab.ca>,
web <http://a2a2000.gmcc.ab.ca>.

Assistance 2000 Employee Assistance Program Conference

May 10-12, Lesser Slave Lake, Alberta.
Contact: Rick Sawchuk,
tel (780) 420-7670.

Prairie Province Conference on Fetal Alcohol Syndrome

May 11-13, Winnipeg, Manitoba.
Contact: 2000 Manitoba Conference
on FAS, Manitoba Children and Youth
Secretariat, 100-233 Portage Avenue,
Winnipeg, MB R3B 2A7,
tel (204) 945-2266,
fax (204) 948-2585,
e-mail <childrenfirst@cys.gov.mb.ca>.

National Conference on Women and HIV/AIDS

May 25-28, Toronto, Ontario.
Contact: The Events Team, Canadian
AIDS Society, 900-130 Albert St.,
Ottawa, ON K1P 5G4,
tel 1-877-998-9991,
fax (613) 563-4998,
e-mail <women@cdnaids.ca>.

30th Annual Meeting of the Jean Piaget Society: Society for the Study of Knowledge and Development

June 1-3, Montreal, Quebec.
Contact: Dr. Cynthia Lightfoot,
Jean Piaget Society, Penn State
Delaware County, 25 Yearsley Mill
Road, Media, PA 19063-5596, USA,
web <www.piaget.org>.

A Vision for You: Recovery in the Millennium

June 4-7, London, Ontario.
Contact: Janis Cramp,
tel (519) 624-8853,
fax (519) 624-1383,
e-mail <adrao@kwigs.net>.

Beyond 2000: Healthy Tomorrows for Children and Youth

June 14-18, Ottawa, Ontario.
Contact: Shelley Callaghan,
tel (613) 798-8029,
fax (613) 798-2422,
e-mail <scall@magma.ca>,
web <http://www.cich.ca/html/
new.htm#resources>.

CAMH / CMHA Conference 2000

June 22-23, London, Ontario.
Contact: Lianne McKay,
tel (416) 535-8501 ext. 4253,
e-mail <lianne_mckay@camh.net>.

UNITED STATES

A System of Care for Children's Mental Health: Expanding the Research Base

March 5-8, Clearwater Beach, Florida.
Contact: Maria Peas,
tel (813) 974-4661,
web <http://rtckids.fmhi.usf.edu>.

National Student Assistance Conference

March 6-9, Nashville, Tennessee.
Contact: NSAC, 1270 Rankin, Ste. F,
Troy, MI 48083-2843,
tel 1-800-453-7733,
fax 1-800-499-5718.

International Conference on Physician Health:

Recapturing the Soul of Medicine

March 29 - April 2, Seabrook Island,
South Carolina. Contact: American
Medical Association, Physician Health
Program, 515 North State Street,
Chicago, IL 60610,

tel (312) 464-5073,
e-mail <elaine_tejcek@ama-assn.org>,
web <http://www.ama-assn.org>

National Conference on Cannabis Therapeutics

April 7-8, Iowa City, Iowa.
Contact: Patients Out of Time,
tel (804) 263-4484,
e-mail <patients@medicalcannabis.
com>.

North American Syringe Exchange Conference (NASEC)

April 26-29, Portland, Oregon.
Contact: NASEN, 535 Dock St., #112,
Tacoma, WA 94802,
tel (253) 272-4857,
fax (253) 272-8415.

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Contact: SALIS,

e-mail <salis@arg.org>,

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ABROAD

1st International Congress of Doctoral Research on Social Psychology

February 8–11, Barcelona, Spain.

Contact: Conference organizers,

e-mail <international.congress@
cc.uab.es>.

6th World Congress on "Innovations in Psychiatry – 2000"

April 3–7, London, UK.

Contact: 6th World Congress Secretariat,

P.O. Box B135, Huddersfield HD1 1Y9,

United Kingdom,

tel + 44-1484-532102,

fax + 44-1484-425699,

e-mail <worldforum@aol.com>.

Jersey 2000: 11th International Conference on the Reduction of Drug Related Harm

April 9–13, Jersey, Channel Islands, UK.

Contact: e-mail <hrc@hit.org.uk>,

web <http://www.jersey2000.co.je>.

15th International Conference on Alcohol, Drugs and Traffic Safety

May 22–26, Stockholm, Sweden.

Contact: Nyman & Schultz AB, Box

1326, SE-111 83, Stockholm, Sweden,

tel + 46 86 98 04 90,

fax + 46 87 91 85 84,

e-mail <specialprojekt@nymans.se>,

web <www.ICADTS2000.com>.

Psychology After the Year 2000

June 12–14, Haifa, Israel.

Contact: Psychology Conference,

c/o Comtec, P.O. Box 68,

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tel + 972 3 5666166,

fax + 972 3 5666177,

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PERIODICALS READING ROOM

Humanities & Social Sciences

smart reform:

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For several years, he freelanced for
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throughout Western Canada.

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SOLANGE DE SANTIS is a former staff
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self-portrait before
getting clean
[from my addiction to
marijuana]. It is an image
of me trying to project
happiness, with a happy
face nailed to my head."





Letters

CONTRARY TO DR. VIVEK KUSUMAKAR'S comments in his November/December editorial, electroconvulsive therapy (ECT) still produces a generalized seizure via the passing of an electrical current through the brain – just as it did in 1938. The introduction of oxygen, anesthetics and muscle relaxants in the 1960s has not changed this fact.

In neurology, the adverse effects of seizures are well known. Many epileptic seizures are not as diffuse, prolonged or violent as the seizures characteristic of ECT (which require muscle relaxants to prevent bone fractures). Such effects may be magnified in elderly persons, who today constitute the bulk of ECT recipients.

There are copious examples from the neurological literature describing seizures as causing "progressive neuronal dysfunction and loss." Yet Kusumakar asserts that "there is little if any evidence of structural brain damage following ECT..." Perhaps psychiatrists and neurologists inhabit different scientific universes, as no such observations appear in psychiatric journals.

The debate on the pros and cons of ECT must include the informed perspectives of neurologists, who are recognized experts on the brain and the effects of closed-head injuries.

David Cohen, PhD
Professor, School of Social Work
Université de Montréal

News from the Centre

The Centre believes that priority must continue to be given to creating mental health and addiction systems that include a full continuum of institutional and community-based care, client-centred programs, and mechanisms for the support of caregivers. These services must be incorporated into a system that can meet individuals' broader health needs fulfilled by access to housing, employment, income and social supports.

However fear, ignorance and negative beliefs still act as barriers to many people seeking services, securing housing or work, or even social supports. Efforts to increase understanding and reduce stigma are critical to fundamental systemic change. The following reflect some of the Centre's efforts in this area:

- Plans are underway to develop and implement a two to three year multi-faceted **public awareness campaign** on mental health and addiction. The campaign will strive to relate to the public on a personal level: messages will aim to demystify myths about mental health problems and addictions, and motivate people to seek help for themselves or others, as well as shift their perceptions, attitudes and beliefs. Plans include securing sponsors and other external resources to cover the campaign costs.
- Through the **Stigma of Addiction** project,

the Centre is working with community partners to learn more about the stigma related to substance abuse, so as to then develop effective messages for the public awareness campaign. Information on the Stigma of Addiction project can be found at <sano.arf.org/stigma/news/htm>.

- The Centre is actively involved in **Media Watch**, a work group of the Mental Health and Addictions Community Coalition, which is focusing its efforts on eliminating negative stereotypes, slang and inappropriate jargon related to mental health and addiction in the news, print and broadcast media. The group plans to expand Media Watch outside of Toronto, and across Ontario.
- The Centre is proud to have supported *Working Like Crazy*, a documentary film that examines the lives of people working in psychiatric survivor-driven businesses. The film has the potential to dramatically challenge public perceptions about mental illness. It was screened across Ontario last fall and broadcast on TVOntario on March 22.
- This *Journal* continues to use the artwork of people who have received services for a mental health or addiction problem. In addition, several people who have received services, and are professional writers, have been contracted to contribute freelance articles.

Downloaded

What Makes A Great Web site?

Evaluation Checklist for Safe Surfing

Scoring: the more checks, the better!

1. Overall Usefulness

- ☐ Did you find what you needed?
- ☐ Will you return to this site or recommend it?

2. Authority/Purpose /Audience

- ☐ Is the producer/host obvious?
- ☐ Is it up front about its objectives (e.g., advocacy/policy/consumer health)?
- ☐ Is there contact information (mailing address, telephone, etc.)
- ☐ Is the target audience clear (e.g., professional/public)?

3. Upkeep

- ☐ Is it being maintained and updated?
- ☐ Is relevant, older information archived and easy to find?

4. Content

- ☐ Is it original?
- ☐ Is there substantive full text information?
- ☐ Are jargon and acronyms defined?
- ☐ Is it appropriate for the target audience(s)?
- ☐ Are documents clearly dated and sourced?
- ☐ Are disclaimers and copyright information included?

5. Features

Are there features that make the site more useful and appealing? Some examples:

- ☐ Search Engine
- ☐ Library Catalogues, Databases, Directories, Virtual Library
- ☐ Good, well organized external links to related sites
- ☐ Interactive tools (registration, ordering, quizzes, diagnostic tools etc.)
- ☐ Access to chat rooms

6. Virtual Libraries

Databases, including library catalogues, are a very useful feature that warrant special consideration. Virtual libraries are certainly the way of the future. Be aware that the scope of these libraries is limited to public domain documents or documents with permission to reproduce.

- ☐ Is the producer provided?
- ☐ Is the scope well defined (subject area, geography, type of literature)?
- ☐ Are search results available in a continuous list to simplify printing or saving the complete set?

Now for the test. Check out the site of the **Center for Mental Health Services** (www.mentalhealth.org) and see how quickly you can find the first U.S. Surgeon General's Report on Mental Health entitled *Mental Health: A Report of the Surgeon General 1999*. How would you rate this site?

This checklist is condensed from *SALIS News* 19 (2) 1999. Anyone interested in the complete checklist may contact the author at <library@camh.net>.

SHEILA LACROIX

In Brief

GHB to be strictly regulated

Gamma hydroxybutyrate (GHB), one of the so-called "date rape drugs," could soon find itself in a category of drugs strictly regulated in America by the federal Controlled Substances Act. Drinking only a few drops of this colourless, odourless substance can render someone unconscious in less than 20 minutes. It can also trigger memory loss. As the drug can leave the body in less than 24 hours, it is often very hard to trace. GHB is often mixed in bathtubs at parties from instructions readily available on the Internet and consumed for its pleasurable high. The law currently being considered by Congress would make the drug illegal to possess with the intent to manufacture, distribute or dispense.

Obsessive bodybuilders may need help

Muscle dysphoria, otherwise known as bigorexia, is a type of body dysmorphic disorder particular to men. Though body-building is a healthy form of exercise, when done to excess it can interfere with leading an ordinary life. Some have been known to continue to exercise even after they've dislocated a shoulder. Considered an obsessive-compulsive type of psychiatric disorder (though not yet officially recognized as one), it can be managed with psychotropic drugs and psychotherapy. Body dysmorphic disorder affects an estimated one to two per cent of the population, according to Eric Hollander of Mount Sinai Medical Center.



Zyban effective and popular among smokers trying to quit

Since it became available for use in Canada a year and a half ago, more than 800,000 prescriptions for Zyban have been filled. With some nine per cent of Canadian smokers (580,000 people) having used the drug, it is the most widely used method in Canada for those trying to kick the nicotine habit. In a recent study (involving 900 smokers) published in the *New England Journal of Medicine*, those using Zyban were almost twice as likely to quit smoking within a year than were those using nicotine gum or taking placebos.

Comprehensive second-hand smoke report released

In late November, the National Cancer Institute made available the most comprehensive study yet undertaken on the health effects of second-hand smoke. Though environmental tobacco smoke (ETS) has long been recognized by the U.S. Surgeon General as causing lung cancer, this is the first report to link ETS with coronary heart disease. It also reveals increased morbidity and mortality in children exposed to ETS. The report was heralded as the next key tool towards creating a smoke-free society.

Caregiving can lead to mortality

Elderly caregivers who tend spouses with such ailments as arthritis and Alzheimer's disease are 63 per cent more likely than other spouses to die within four years. Tracking 819 spouses aged 66 to 95, researchers at the University of Pittsburgh found that 317 of the spouses studied provided substantial care around the house for their spouse. Of the 317 caregivers, 179 reported being depressed and not being able to exercise or see a doctor for personal ailments. The researchers suggested providing at-home caregivers with outside support to prevent them from falling ill.

Students screened for anti-social behaviours

In the wake of last year's shooting at Columbine High School in Colorado, some American schools are implementing psychological profiling tools designed to weed out potentially violent students. Though homicides in American schools are extremely rare, intro-

ducing student profiling is often considered invaluable in helping anxious parents and school administrators to feel more secure. Detractors are quick to point out that this testing might undermine the climate of learning at schools, as well as encourage rumour mills, fear mongering and unwarranted condemnation of misfit students. However, its proponents argue that the testing will enable proper psychiatric interventions for troubled youth.

In-store coupons stimulate condom sales

High value discount coupons for condoms located at the point of purchase have been shown to be successful in promoting condom sales. In a 1995 Vancouver-based study, researchers at the University of British Columbia examined the effectiveness of different methods of coupon distribution using two types of discounted coupons (75 and 10 per cent). Distributing the coupons on a wide-scale basis at venues such as bars and fitness clubs had a negligible impact, while distribution of coupons in stores produced high redemption rates. Understanding the purchasing patterns of those who buy condoms might allow health organizations to better target and carefully implement safer-sex promotional programs. Using safer sex methods reduces the harms associated with the abuse of certain drugs.



"Chasing the dragon" creates spongy holes in the brain

Neurologists in New York have found that inhaling heroin fumes can cause spongy holes (spongiform leukoencephalopathy) to appear in the brain. Through a popular method known as "chasing the dragon," users heat up their heroin and inhale it through a straw made from aluminum foil so as to prevent contracting infectious diseases from dirty syringes. Magnetic resonance imaging scans of the brains of people afflicted with spongy holes revealed a pattern similar to that caused by poisoning from the neurotoxin triethyltin. As there are only trace amounts of tin in the aluminum foil, the hypothesis that the tin is to blame has been discounted. The exact cause of the spongy holes is still unknown.

CHRIS HENDRY

Drunk drivers who kill: Finding ways to make them STOP

IN KENTUCKY, A MAN WALKS FREE AFTER 11 YEARS IN JAIL FOR causing a drunk driving accident that killed 27 people on a bus in a head-on collision. In North Carolina, another U.S. drunk driver is sentenced to life without parole and narrowly avoids the death penalty. The question that hangs in the balance isn't solely whether or not justice has been served when punishing a DWI (driving while impaired) offender. It's what are the best ways to deter this dangerous and often fatal behaviour.

In some nations, lowering the legal alcohol limit seems to be successful. In Sweden, for example, the legal limit was recently lowered from 0.05 to 0.02: research suggests that this decrease is associated with a six to nine per cent reduction in fatal collisions. In Canada, where the legal limit in the Criminal Code remains at 0.08 per cent, Transport Canada estimates that about 1,350 people die each year in alcohol-related motor vehicle crashes. Thousands more are seriously injured.

Licence suspension seems to be another good motivator for changing drinking-driving behaviour. In Manitoba, 74 per cent of participants in the province's mandatory Impaired Driver's Program reported in a survey that the primary motivation for changing their behaviour was fear of losing their licence.

However, Dr. Robert Mann, PhD, senior scientist with the Centre for Addiction and Mental Health (CAMH), says stand-alone measures won't work in reducing alcohol-related road injuries and fatalities. "You can't simply substitute licence suspension for rehabilitation," explains Mann, who is also an associate professor of public health sciences at the University of Toronto. "Moreover, just increasing the penalties isn't a general deterrent if no one knows about it. Drinking drivers need to have the perception that the laws apply to them. That's why initiatives such as the RIDE program in Ontario, which combines high visibility enforcement with public education, have helped reduce drinking-driving fatalities since the early 1980s." In Canada, the federal government is also considering raising the maximum penalty for impaired driving causing death from 14 years to life imprisonment.

The main approach for reducing drinking-driving among repeat offenders is to provide education and therapy, backed up by stiffer penalties. Ontario recently joined other Canadian provinces in adopting a remedial measures program. The CAMH manages this program on behalf of the Ministry of Health, and in co-operation with the Ministry of Transportation. As of September 30, 1998, first-time offenders complete an eight-hour educational program, while second-time offenders are assessed and assigned to either education or treatment and complete a follow-up. (The program costs participants \$475.)

New measures in Ontario also call for longer suspension periods, an

ignition interlock system (a breathalyzer-like device that must be passed before drivers are able to start up the car), and a 10-year blight on one's record for Criminal Code convictions related to drinking-driving offences.

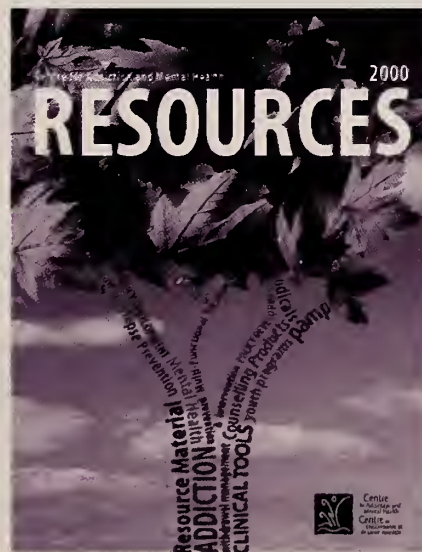
Similar programs are operating elsewhere in Canada. For example, the Addictions Foundation of Manitoba's Impaired Driver's Program involves a mandatory assessment of DWI offenders (at a cost of \$270), which determines where to refer offenders – be it to an educational workshop, treatment program or something else. A survey revealed that more than 80 per cent of participants had made changes to their lifestyle as a result of the program, while 44 per cent reported that they now "never drink and drive."

Education and treatment are effective in helping drinking drivers to reform their actions, according to a meta-analysis that examined remedial program studies from around the world. While licence suspension reduces exposure to DWI incidents, the biggest success occurs by combining interventions, including suspensions, education and treatment, says Dr. Beth Wells-Parker, PhD, lead researcher on the groundbreaking study out of Mississippi State University. "We measured a seven to nine per cent average reduction in recidivism and crash rates as a result of such measures, and that's a fairly substantial effect when specific to alcohol-related events." However, she adds that while remedial measures are superior to using no intervention, they're not a magic bullet either.

Mann agrees, "We need to find out how our measures work best in combination to achieve maximum road safety." ■

ANGELA PIRISI

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Supports For Higher Education

WHEN PEOPLE WITH A PSYCHIATRIC disability enter university or college, they are usually reluctant to disclose their disability due to the stigma associated with their mental illness. Yet the success of their academic career can often hinge on this very disclosure.

This inherent tension is highlighted in the initial findings of the Supports for Higher Education Project currently being conducted by the Canadian Mental Health Association (CMHA), National Division. The study, which involves consultation with students, faculty and staff at six colleges and universities across Canada, has been created to identify existing problems and to develop and promote "best practices" for supporting students with psychiatric disabilities in higher education. Strategies include making information about existing supports more readily available, instituting public education programs, changing existing disability policies to take into account the episodic and cyclical nature of mental illness, and making greater use of peer support groups and peer mentors. The six institutions involved are York University and University of Toronto in Ontario, Athabasca University in Alberta, the University of Manitoba, University College of Cape Breton in Nova Scotia, and Northwest Community College in British Columbia.

The study has found existing supports available for students with psychiatric disabilities to be "uneven at best." When these supports are available, students still aren't necessarily making use of them.

Students with psychiatric disabilities often have problems with concentration, short-term memory, fatigue, as well as periodic crises related to their illness. As a result, they may require certain accommodations, such as extensions on assignments, or permission to write exams separately from the rest of their class. Or they may need to drop classes without financial penalty. But to qualify, they will need to disclose their disability. Students are often reluctant to do so: they may not be aware that the accommodations are available, or they may find it too difficult to admit that they have a mental illness.

Enid Weiner, Coordinator of the Psychiatric Dis/Abilities Program at York University, found that in the past students "would take a course,

have to withdraw early, take it again, withdraw, and they were continuing to pay each time they took the course." (Now students are less likely to fall into this costly cycle, in large part due to the emergence of programs such as the one at York that offers counselling to students and assists them in navigating the bureaucracy of higher education.)

Another peril occurs "if people don't disclose and they develop a crisis. Then they end up being disclosed through the crisis," notes Heather McKee, who heads the Supports for Higher Education Project. This makes some professors concerned about students being disruptive: of their having a psychotic break during a class, or exhibiting severe depression and suicidal tendencies in the residences, McKee says. However she insists that only a small minority of the academic community has these concerns.

Students with psychiatric disabilities typical-

ly face a difficult learning curve as they adjust to higher education. Weiner finds that "when students come in initially, especially if they've just been diagnosed, they're still testing themselves, so maybe they take on too much. And then they learn through trial and error what they can manage and what they can't manage." Her advice: "Go slower and you'll get there. If you try to push yourself you might lose everything."

One of the keys to success involves creating a support network of family, friends, peer mentors, counsellors, tutors and the like. Support groups for students with psychiatric disabilities are beginning to emerge on a number of campuses and are helping to overcome the isolation that many experience. Ed Pomeroy, who headed the pilot project for the CMHA study at Brock University, says that it was critical for these students to have a support person who believes in their ability to succeed in higher education. "If you try and do this by yourself, you're really at risk of hitting the wall, withdrawing, and becoming another casualty in the educational race." ■

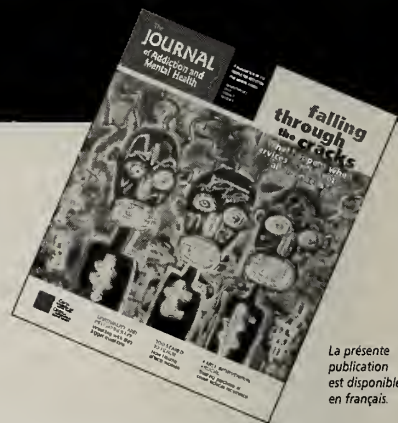
MARK DE LA HEY

More information on this project is available on the Supports for Higher Education Web site at <www.cmha.ca>.

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Fighting Traffic

Gil Puder – in memorium

GIL PUDER DIDN'T DISLIKE THE DRUG PROBLEM; HE HATED IT. He knew Vancouver's east end, one of the toughest drug crime areas, like the back of his hand. A black belt in karate, he taught street fighting. And as an 18-year veteran of the Vancouver Police Department, he was one of the most unlikely crusaders against "the war on drugs."

Puder's background was in competitive sports and joining the police force was a natural fit. "I was playing for the right team," said Puder, "and we were playing to win."

He was as gung-ho as the next cop. But in 1984, his attitude began to change after he shot and killed an armed drug addict who had robbed a bank. Two years later, during a drug raid, a junkie took the life of one of his best friends, Sgt. Larry Young.

Years of witnessing corruption and carnage first-hand led to his growing doubt about the logic of drug prohibition. And then his darkest day came in 1997. He had been assigned to notify a mother that her son had died of a drug overdose. "I had never in 15 years of policing had to deal with somebody who was so inconsolable."

For Puder, that was the defining moment in his war on drugs. As a matter of conscience, he wrote an op-ed piece for the *Vancouver Sun* about the futility and wrong-headedness of the war on drugs. He urged people to see drug abuse as a health issue rather than a law enforcement issue and called for the decriminalization of drugs. "The windfall savings on law-enforcement dollars could be plowed into health care, education and rehabilitation, which are the only methods proven to correct substance abuse," he wrote. Unbeknownst to him, this article would change his life. "[T]he world overtook me overnight and I got sucked into this vortex of drug policy reform," laughed Puder.

"He was the first beat cop in Canada to speak out publicly against the war on drugs," said Eugene Oscapella, founder of the Canadian Foundation for Drug Policy in Ottawa. "I congratulated him and offered whatever support I could."

Oscapella first met Puder in April 1998, when they were both invited to speak at "Sensible Solutions to the Urban Drug Problem," a conference held by the Fraser Institute in Vancouver, B.C. "He was much more than a beat cop," said Oscapella. "He was an extremely intelligent and thoughtful person. He vacuumed up information at an enormous rate and articulated it beautifully."

As Puder once declared on film: "The reason that we should give up on drug prohibition is not that it isn't perfect. It's that there is absolutely nothing right with it. Drug prohibition does exactly the opposite of what it was intended to do. Drug prohibition creates violence. It creates more addicts. It creates more dysfunction in society."

Puder argued that as long as drugs are illegal, politicians will destroy the integrity of the police by forcing them to break the law to enforce it.



Gil Puder

"And once you develop that cheating mentality, anything goes," he said.

Puder believed that there would always be a demand for drugs, and that making them illegal just drives the profits up. When there are huge profits to be made, the drug traffic continues. "If we want to stop the traffic, we have to take the money away."

Not surprisingly, Puder's comments weren't welcomed by the police force and attempts were made to stop him from speaking publicly. His outspokenness eventually made him the target of threats and a smear campaign. Although some of his colleagues in the force privately supported him, none were brave enough to do so publicly.

But none of this shook his conviction that the war on drugs was futile and that he had to do something about it. Puder was destined to go far beyond the role of police officer and was being courted by the Liberals for political office," said Oscapella.

Puder made headlines as he fought for and won his legal right to speak out as a private citizen. The battle caught the attention of Vancouver filmmaker Jerry Thompson who featured Puder in his recent documentary, *Stopping Traffic: the War Against the War on Drugs*. "No one really hears about the growing minority against the war on drugs, and especially not from cops who are generally seen as right wing," said Thompson.

"For Gil, being part of this film was the right thing to do," Thomson said. "He would often allude to a quote by the late Chief Justice of Canada Brian Dickson: 'Publicity is the very soul of justice and the surest of all guards against impropriety.'"

Puder wrote articles that appeared in various professional journals and made numerous radio and television appearances. He was a speaker in demand at international conferences on drug policy. Sadly, he did not get to complete the final draft of his book, *Crossfire: A Street Cop's Stand against Violence, Corruption and the War on Drugs*. It was to be published last fall.

Gil Puder, 40, died of skin cancer on November 12, 1999. ■

HONEY FISHER

Research Update

Mothers with eating disorders struggle with infant feeding

Mothers with eating disorders often have difficulty adequately feeding their infants at mealtime due to conflicts that arise over such issues as the infants making a mess or attempting to feed themselves. This appears to account for earlier findings that the infants of mothers with eating disorders tended to weigh less than infants in a comparison group. The researchers studied 34 mothers with eating disorders and their 12-month-old infants, along with a comparison group of 24 mothers and infants. They found that mothers with eating disorders "were particularly stressed by mealtimes." They were also less likely than the mothers in the comparison group to recognize the infants' need to exert their own autonomy at mealtime. The authors concluded that such mothers may need help in "learning to recognize and respond appropriately to their infants' signals at mealtimes," setting aside their own aversion to mess and infant self-feeding. (M.H.)

British Journal of Psychiatry, November 1999, v. 175: 455-461. Alan Stein et al, Royal Free and University College Medical School, University College London, London, United Kingdom.



Schizophrenia may lead to learning disabilities

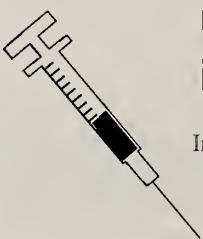
A Scottish study has found that the brains of individuals suffering from both a learning disability and schizophrenia resemble more closely the brains of individuals suffering from schizophrenia than those with a learning disability alone. This suggests that the high frequency of schizophrenia among the learning disabled is not caused by the learning disability. Rather, the learning disability appears to be a consequence of the schizophrenia. The study examined 20 patients with a learning disability, 25 with schizophrenia, 23 with both disorders, and 29 controls, employing magnetic resonance imaging (MRI). Results indicated that the whole brain volumes of those with both disorders were similar to those with schizophrenia alone, while the volumes of the learning disabled were significantly smaller, and the volumes of the controls were the largest. Comparison of brain ventricles showed that the learning disabled had the largest ventricular volumes, while the controls had the smallest. People with schizophrenia and those with both disabilities were in the middle range. (M.H.)

Lancet, November 27, 1999, 354: 1867-71. T.L. Anderson et al, Royal Edinburgh Hospital, Edinburgh, United Kingdom.

Poverty inhibits intellectual development of inner-city children

Past reports have indicated that infants exposed to cocaine before birth exhibit serious cognitive problems and impulsive behaviour. However, a study of inner-city children in Philadelphia has found that cocaine-exposed children differ little from their inner-city peers in terms of attention and organized behaviour. Seventy-two cocaine-exposed children and 81 control subjects were tested through a problem-solving exercise. The two groups showed no statistically significant differences in problem-solving ability, indicating that exposure to cocaine was not a huge factor in inhibiting the development of problem-solving skills. Interestingly, both inner-city groups proved to have significantly lower scores when compared with a third group from a mixed socio-economic background. The lower scores of the inner-city children were associated with lower socio-economic status and "pervasive disadvantage" (e.g., poorly educated parents and violence). (M.H.)

Developmental and Behavioral Pediatrics, December 1999, 20 (6): 418-424. Laura Betancourt et al, Albert Einstein Medical Center, Philadelphia, Pennsylvania.



Unsafe injections common in developing world

In 14 of 19 developing countries, at least half of injections given for medical purposes were found to be unsafe (involved reusing an unsterilized needle), according to a literature review. The review concluded that, as a result, the "transmission of blood-borne pathogens through unsafe injections is a common event in developing countries." Ninety-five per cent of all injections in the countries studied were deemed unnecessary: they were often used to deliver vitamins, antibiotics and analgesics for which oral alternatives exist. Unsafe injections were linked to transmission of hepatitis B and C, HIV, Ebola and Lassa virus infections and malaria. Sometimes these infections led to serious outbreaks. (M.H.)

Bulletin of the World Health Organization, 1999, v. 7 (10): 789-800. L. Simonsen et al, World Health Organization, Geneva, Switzerland.

Smokers who quit without treatment

When it comes to quitting smoking, most treatments have low success rates, and most people who succeed in quitting do so on their own. This led researchers at the University of Alabama to study 40 individuals who were able to quit smoking without formal treatment, and who had been tobacco-free for at least five years. The findings revealed a number of similarities in their approaches to quitting. Most were motivated by the realization that they were indeed addicted to tobacco, although some insisted that their smoking was a habit, not an addiction. They most often used substitution (for instance, substituting chewing gum for tobacco) or a change of environment (such as taking time off work). Almost all had tried unsuccessfully to quit in the past: these attempts appeared to be important in their learning to identify situations that had impeded past efforts. (M.H.)

Journal of Drug Issues, Winter 1999, v. 29 (1): 167-186. Chris Stewart, University of Alabama, Tuscaloosa, Alabama.

Are women in prison bad mothers?

In 1991, more than three-quarters of women in American prisons had children. Yet the correctional system does not necessarily provide these women with adequate support to maintain ties with their children, due to negative perceptions of them as mothers. Pamela J. Schram surveyed attitudes among 74 female inmates, 29 peer counsellors, 21 correctional officers and 27 program staff. She found that correctional officers and program staff were the most likely to view female inmates as bad mothers, while peer counsellors and female inmates themselves were the most likely to have positive views about inmates as mothers. This was true despite the fact that female inmates had the most sexist attitudes toward women, "followed closely by correctional officers," while program staff, and then peer counsellors, had the least sexist attitudes. Female inmates and peer counsellors had the most positive attitudes about inmates maintaining ties with their children and about child visitation. (M.H.)

Journal of Criminal Justice, September/October 1999, v. 27 (5): 411-426. Pamela J. Schram, California State University, San Bernardino, California.

Why can't I just get some sleep?

Individuals over 65 should be asked about their alcohol use when getting a prescription filled, said researchers at Boston College. Researchers studied 19 elderly individuals who reported daily alcohol consumption and sleep problems so as to gain insight into concurrent use of alcohol and medications. (Older persons frequently report sleep disorders and often use alcohol or sleep medications to help them sleep.) Eighteen of the 19 individuals studied were taking medications that could have serious, adverse effects if taken with alcohol, and 16 of the 19 reported experiencing sleep disorders. To mitigate negative consequences, researchers advised that health care professionals ask elderly about their alcohol use. The researchers also recommended that professionals assess the elderly for drug/alcohol interactions and that caregivers recommend non-pharmacological interventions for sleep disorders. (C.H.)

Journal of Substance Use, 1999, v. 4 (3): 147-154. Patricia Tabloski et al., Boston College School of Nursing, Chestnut Hill, Massachusetts.



Predicting burnout in AIDS volunteers

Many volunteers who work with AIDS patients are giving up their careers due to burnout. Leaving their jobs is often precipitated by such stresses as client problems and role ambiguity; as well as emotional overload and organizational factors, coupled with depersonalization. Researchers at the University of Texas observed this correlation while studying a group of 174 AIDS volunteers to determine what predicts dropout over time. AIDS volunteers are a key link in the HIV/AIDS care system and their efforts are widely believed to reduce the care cost per patient from \$150,000 to \$40,000 per year. Understanding what causes these volunteers to quit might help prevent the loss of such dedicated personnel. (C.H.)

AIDS Care, December 1999, v. 11 (6): 723-731. M. W. Ross et al., University of Texas, Houston, Texas.

Pre-teens consider it cool to bully weaker playmates

Schoolyard bullies may actually be popular with their schoolmates. In examining 452 boys in Grades 4 through 6, researchers at Duke University found that approximately a third of the boys were popular when exhibiting anti-social behaviours. Peers, thinking schoolyard ruffians to be cool, anti-social and athletic, may actually contribute to the wayward students' negative behaviours: the bullies may then internalize a connection between violence, popularity and control. Though the antics of bullies might be socially beneficial in the short run, researchers are unsure about the effects of such behaviours in the long term. (C.H.)

Developmental Psychology, January 2000, Vol. 36 (1): 14-24. Philip Rodkin et al, Duke University, North Carolina.

MARK DE LA HEY, CHRIS HENDRY

Making it work: Linking productivity and mental health

BY SOLANGE DE SANTIS

AS SKILLS IN THE WORKPLACE INCREASINGLY REQUIRE BRAIN power, rather than physical dexterity, employees need to think clearly to work effectively.

Dr. Edgardo Pérez, CEO and chief of staff, Homewood Health Centre, summarizes this perspective in the subtitle of a book he co-authored called *Mindsets, Mental Health: The Ultimate Productivity Weapon*. Pérez argued that mental health is at the forefront of workplace issues now because we are in an economy that depends on knowledge, and thus clarity of thought, more than physical skill.

People need to be able to concentrate and be creative in "knowledge jobs." Therefore they "need to be well-positioned emotionally," he says. The role of manager is changing, he adds. Part of the chief executive officer's job will be "creating an emotional environment for people to thrive."

This means offering employees flexibility, compassion and creativity, whether simply in an effort to minimize their stress, or work around more serious mental health problems. As award-winning features writer Sandy Naiman asserts, "People with mental illness are not disabled. They work hard to compensate for their mental illness, and they have a supreme desire to work well."

Being productive in the workplace requires that the employee follows through on assignments, and that the employer in turn creates a supportive environment to ensure that this occurs. Naiman's experience at *The Toronto Sun* newspaper is a prime example of how this collaborative relationship can work.

Naiman has coped with repeated bouts of mania for the 22 years she's been employed by *The Toronto Sun*. Over the two decades, she has been hospitalized 11 times due to psychotic behaviour. But Naiman has also been a very productive and outstanding writer during this time, say her

editors. In return, her employees have displayed creativity and compassion in meeting her needs. For instance, a problem developed over noise in the newsroom.

"I am disruptive. I am very loud. I get very involved in my interviews," Naiman says flatly. Lifestyle editor Joanne Richard, Naiman's supervisor, noted that people sit close together and that reporters do a lot of work over the phone. So the solution was to allow Naiman to work at home. "Sandy can get more work done and so can her colleagues," Richard says.

Crafting such solutions is more work for a manager and a corporation, but "you get it back tenfold," says Trudy Eagan, vice president and chief administrative officer of Sun Media Corp., which owns *The Sun*. And as Richard asserts, "Sandy is an excellent writer and a very valuable employee. We are in many ways privileged to have her."

When Naiman is manic, she often does things that she later regrets. "In August, I phoned various senior people convinced I should be a Sunshine Girl. I was finally stopped and told to take a couple of days off."

When she returned to work after a brief hospitalization, and adjustment of her medication, following the Sunshine Girl episode, Naiman said the managing editor told her, "Don't worry about it. We love you." But for Naiman, returning to work was daunting. "You've been away, and you know where you've been, and you remember some embarrassing things you said when you weren't well," she says.

Though it has not been Naiman's experience, fellow workers will often respond with uneasiness to their co-workers' difficulties, according to Pat Fryer, Director of Occupational Health and Safety at the Centre for Addiction and Mental Health. "We've run across resentment," she says. Some people feel that the returning employee is not doing a full job, and so they wonder why they should put in full hours for the same pay, says Fryer. Co-workers don't have to be told why an employee was off for a while, but managers can appeal to a sense of teamwork and some enlightened self-interest. Fryer suggests that, if possible, some part-time help be added during employees' re-adjustment period, so the burden of work is spread around.

A healthy workplace is good for everyone, and no less so for someone coping with a mental health problem. However, according to a 1994 Statistics Canada survey, only 25 per cent of people with a mental disorder are employed. "People have to feel they are useful," Fryer says. On a basic level, going to work gets people out of the house, where they can feel increasingly isolated, she says.

Most managers, of course, are not mental health professionals, nor do they want to invade someone's privacy. So employees with problems may go unnoticed until their troubles "escalate to the point that they are having an impact on productivity," says Shelly Gorchynski, vice president of service operations with Warren Shepell Consultants Corp., the largest provider of employee assistance programs (EAPs) in Canada.

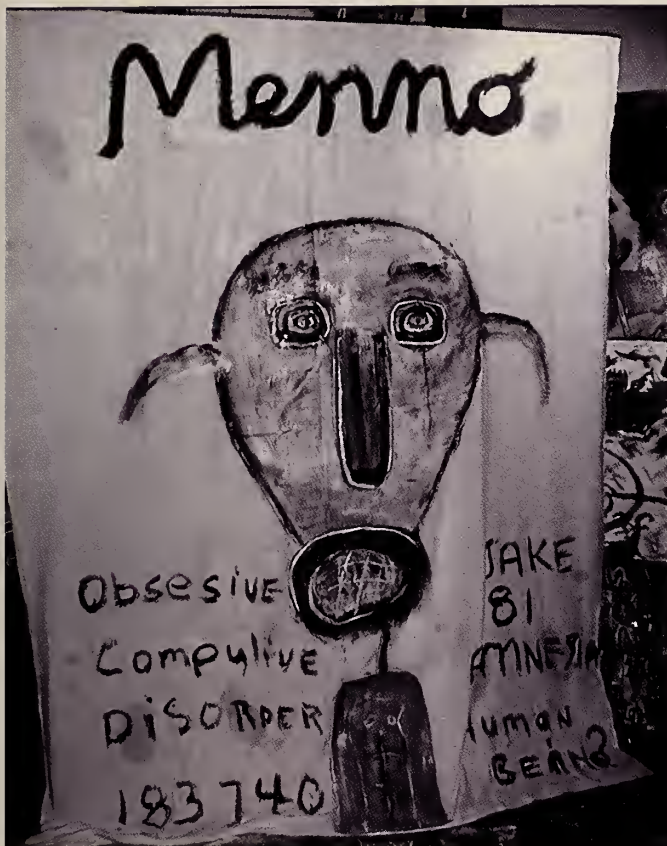
Managers can consult the company EAP counsellors for advice on "how to manage behavioural issues in the workplace," Gorchynski says. "What is desirable is an early intervention," she adds. Such initiatives, and the understanding that goes with them, can go a long way toward reducing the stigma still attached to mental illness.

The best way to reduce the stigma that surrounds mental illness is to talk openly about it, says Naiman, much as you would talk about any medical problem. "You'd be surprised at how compassionate your co-workers can be when they understand that you have a mental illness, and they can see that it isn't frightening," Naiman says. "After all they know you, and it is only the unknown that is frightening. With treatments now available, we are normal people living with a controllable, chronic illness. And it's our responsibility to educate others about this illness. We have to be advocates." ■



Photo: Craig Robertson, The Toronto Sun

Sandy Naiman, recipient of a CAMH Courage to Come Back Award



Artwork by Menno Krant

All in the Family

OCD may be inherited

BY DIANA BALLON

WHEN CLARA WAS ABOUT six-years-old, she obsessively imagined she was ingesting Comet from the container next to the bathtub. By the age of eight, these fears had transferred to beliefs that she was setting bombs and lighting fires in the basement. Midnight forays followed, barefoot, down the cold, dark stairs to the cellar. She was there to extinguish an imaginary fire, and deactivate a non-existent bomb.

For Clara (not her real name) lived with the terror of death and disease with the same sense of imminence felt by many elderly and terminally ill. Like Lady Macbeth, who constantly washed her hands to remove invisible spots, she suffers from obsessive-compulsive disorder (OCD).

OCD afflicts about 2.5 per cent of the Canadian population, and costs the Canadian health care system about two billion dollars per year. For 90 per cent of sufferers, obsessive thoughts and the compulsive behaviours that people perform in hopes of reducing the anxiety – such as incessantly counting things or repeatedly hand washing – occupy about one or two hours each day, over the course of years. Only 10 per cent of OCD sufferers have just one episode.

Like Clara, their secret misery forces them to inhabit tormented internal worlds, withdrawing from many activities in life that might have brought joy. Without knowing the exact cause of OCD, experts surmise that it is likely a combination of genetics, biology and psychological variables. At the most recent conference of the Canadian Psychiatric Association in Toronto, a team of researchers from the Centre for Addiction and Mental Health (CAMH)'s Anxiety Disorders Clinic spoke about the causes and treatments for OCD.

The genetic basis of OCD has been supported by many studies conducted since 1936, all suggesting that OCD runs in families, says CAMH staff psychiatrist Dr. Margaret Richter. Frequently, one or both parents, as well as some siblings and more distant relatives, will have, if not full-blown OCD, then some obsessive thinking, compulsive behaviour and even tics or Tourette's disorder. The fact that the themes of the obsessions or compulsions are frequently different (with father, for instance, ruminating about diseases and daughter obsessing about germs) lends itself to an argument for OCD being hereditary rather than learned.

There is strong support for involvement of serotonin, and more recently for dopamine, in OCD, though no one gene has been found responsible. A genetic basis for the disorder is particularly likely when a child develops it very early on. (About 30 per cent develop OCD by age 15, and approximately 50 per cent by age 20, according to Richter.)

A major breakthrough in OCD treatment occurred in the early 1980s when researchers discovered that the antidepressant clomipramine hydrochloride relieved obsessions and compulsions by inhibiting the reuptake of serotonin after it is released by neurons in the brain.

The introduction of SSRIs (selective serotonin reuptake inhibitors), such as Prozac, in the late 1980s offered enormous relief to OCD sufferers. However just as serotonergic drugs proved successful, drugs blocking the reuptake of noradrenaline (another neurotransmitter used for transmitting signals from one brain cell to another) proved ineffective. More recent studies using PET scans have revealed that people with OCD have abnormal activity in specific brain areas, particularly in the frontal cortex.

Cognitive-behavioural therapy is the treatment of choice in those with mild to moderate OCD, and a suggested adjunct to antidepressants for people with more severe cases, says Dr. Neil Rector, head of the Anxiety Disorders Clinic and assistant professor of psychiatry at the University of Toronto. Cognitive therapy focuses not on the content of the obsession (often related to themes of aggression, sex, contamination, hoarding, disease, religion and a need for symmetry or exactness) but rather the person's appraisal or interpretation of the obsession. A second component of the treatment involves helping clients to reduce compulsive rituals with behavioural strategies. Generally, this part of therapy focuses on modifying behaviours by getting the person to approach or even confront a feared situation without performing the ritual that reduces the anxiety. For example, someone who is excessively afraid of using public washrooms might be helped to actually use the facilities without constantly washing her hands and cleaning the toilet first.

This form of therapy involves minimal involvement of a therapist; in fact, someone can do almost as well merely by following a self-help manual, Rector says. However upwards of 25 per cent refuse this therapy because it requires a lot of commitment, and an ability to tolerate some distress before things begin to improve.

Only about 10 per cent of OCD sufferers are actually identified with the problem, according to Mark Riddle, in a 1998 supplement to the *British Journal of Psychiatry*. The child will likely feel embarrassed by her symptoms, and so ashamed and confused that she may not be able to articulate her fears to parents or a doctor. Riddle thus stresses the importance of a clinician developing a trusting relationship with the child, and assessing the existence of related problems such as anxiety (e.g., separation anxiety disorder) and depression as well as OCD-type symptoms in other family members.

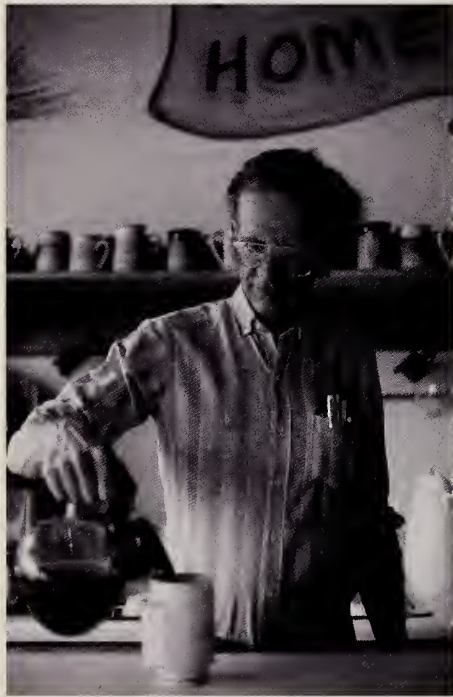
Fortunately for Clara, she had a mother that was disturbed enough by her daughter's concerns to seek out help. Though Clara did not respond to behavioural therapy, she was helped through understanding therapists and through intermittent use of SSRIs, which she continues to require as an adult. ■

Unusual addictions

BY CINDY McGLYNN

When you say "addiction," people typically think of two things – alcohol and drugs. But increasingly, people are using the word to discuss other compulsive behaviours, including shopping, sex – even over-eating. Researchers say excessive behaviour in these areas is not always addiction in the technical sense. But many point out that addiction can be a useful model for treatment for one basic reason: patients understand it. Here are some examples of substances or behaviours which, when indulged in excessively, may be described as addictions. Some of them might surprise you.

1. Caffeine – the most widely used psychoactive substance in the world – is addictive. As many as 92 per cent of North American adults regularly enjoy its mildly stimulating effect. Dr. Peter R. Martin, director of the Institute of Coffee Studies at Vanderbilt University Medical Center in Nashville, Tennessee, says caffeine is socially accepted because it's simply not as dangerous as alcohol or other drugs. "It's a totally different class of agent. People don't destroy their families or rob banks nurturing a caffeine addiction. It's not really that dangerous at all."



Still, side-effects of over-consumption can include irritability, tremors, insomnia and irregular heartbeat. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM IV), consuming more than two to three cups of brewed coffee per day, accompanied by various symptoms, such as restlessness and gastrointestinal problems, can be grounds for "caffeine intoxication."

Gradually reducing intake is the best way to wean off coffee. Stopping cold turkey can bring on withdrawal effects such as headaches, fatigue, decreased activity and alertness.

2. Seems like almost everyone takes themselves for a "carbo-addict" these days. But "addiction" to carbohydrates is more than a run-of-the-mill sweet tooth. It's defined by Drs. Rachael and Richard Ferdinand Heller (authors of *The Carbohydrate Addict's Diet: The Lifelong Solution to Yo-Yo Dieting*) as an uncontrollable desire for carbohydrate-rich foods such as sweets, breads and pasta coupled with an escalating need to eat these foods.

The authors say that as many as 75 per cent of overweight people, and many average-weight people, are carbohydrate addicted. It's a condition they say is caused by over-release of the hormone insulin when carbohydrate-rich foods are eaten. Insulin signals the body to take in food. Once the food is consumed, the insulin then signals the body to store the food energy in the form of fat. Too much insulin results in too strong an impulse to eat, too often, and a body that too readily stores food as fat.

University of Chicago medical researchers found carbohydrate-rich meals also promote release into the bloodstream of a potentially addictive natural tranquillizer called tryptophan. Other researchers say carbohydrates encourage serotonin, a natural antidepressant, to be released. Experts are divided on treatment. Some recommend abstinence. Others say lowering consumption will do the trick, particularly with refined carbs such as white flour and sugar.

3. People who "shop 'til they drop" and max out credit cards may have a shopping addiction. Their aim is usually to combat such feelings as depression, anxiety or loneliness. But increased financial stress from compulsive buying generally makes things worse.

If people shop for a "pick-me-up" and get a rush from purchasing, they may have a problem. Tell-tale signs include regularly buying things that aren't needed, an overwhelming compulsion for specific items such as shoes, and hiding purchases from family members. Research compiled by Prof. Ruth Engs from the Department of Applied Health Science at Indiana University, says shop-a-holics sometimes have emotional black-outs and don't remember buying binges. Professional counselling is usually recommended.

4. Sex addiction is very hard to define, according to Dr. Paul Federoff, staff psychiatrist and head of the outpatient psycho-legal clinic at the Centre for Addiction and Mental Health. So-called sex addicts (their own label) may be involved with Internet sex sites, telephone sex lines, strip bars or prostitutes – and feel they can't control their behaviour. Or they may be having multiple sexual affairs, compulsively masturbating or consistently and increasingly using pornography. The U.S. National Council on Sexual Addiction and Compulsivity reports that between three to six per cent of Americans are sex addicts.

Signs of addiction include: losing the ability to control or stop the activity; and obsessing over it and continuing the behaviour despite negative consequences, such as loss of a marriage or job.

While Federoff says that it's mostly men who show up for treatment, "If you use the definition of engaging in sexual activity that's not good for you even though you know it, clearly there are a lot of women who fall into that category." He says most people seek treatment for the same reasons: financial trouble. "They think what they're doing is unhealthy or, the biggest reason of all – their spouse insists." ■



Curing **sex offenders?**

[smart reform]

BY DIANA BALLON

MOST PEOPLE WOULDN'T CONSIDER GOING TO A FAST food drive-through (rather than eating in the restaurant) as a way of avoiding a high-risk situation. But for a pedophile, it is.

While sitting in on a group therapy session for pedophiles at the Centre for Addiction and Mental Health (CAMH), a fast-food outlet is the example one client gives to describe an environment that places him at high risk of reoffending — because of the temptation posed by being around kids.

The five men that attend this relapse prevention program are doing so as part of the terms of their probation. While their sexual offences related to children may vary widely — from ordering child pornography to fondling children to rubbing up against a teenager on a bus — the treatment remains the same.

Judging on the program's track record, these men have a good chance of not reoffending. In fact, there has been no known recidivism among the approximately 100 participants, while in treatment, since the clinic opened in 1995, says Dr. Howard Barbaree, Clinical Director of the Law and Mental Health (formerly the Forensic) Program. This compares to a recidivism rate worldwide of more than 13 per cent for sex offenders in the four to five years following their release, according to a meta-analysis of 61 studies, involving 23,393 offenders. This percentage goes as high as 40 per cent once offenders have been released for 15 to 20 years.

Sexual offending continues to be a serious problem in Canada as numbers of offenders increase. While current treatment appears to be reducing recidivism rates, there is still not a substantial difference in recidivism for those who are treated versus those who are not, says Karl Hanson, a senior research officer with the Department of the Solicitor General of Canada. As well, there are still not enough longitudinal studies to accurately predict long-term risks, according to a 1996 literature review by K. Blanchette.

At the CAMH's Sex Behaviours Clinic, a multidisciplinary approach combines drug treatments with cognitive-behavioural therapy. And therapists work closely with probation and parole officers to monitor offenders' behaviour while in the community.

Prior to beginning treatment, these men will have undergone a phallometric assessment. As depicted in the adjacent photo, this assesses men's level of attraction to people of various ages and sexes, and is performed by showing the client various slides (e.g., of nude children and adults, both male and female), while measuring level of penile arousal. This can be done by placing a glass cylinder over the penis to



Detail of artwork by Dinita Tymes

measure its volume, or using a mercury in rubber strain gauge to measure its diameter.

The phallometric assessment is one of the best ways to predict someone's future behaviour in cases of sexual deviancy, such as pedophilia, says Michael Kuban, manager of the phallometric lab at the CAMH. However this assessment does not necessarily predict a man's chance of reoffending in cases of rape.

Once having been assessed, the men will then move through four stages of therapy. In stage one, the focus will be on accepting responsibility for the offence. It will also involve developing empathy for the victim: in one exercise, the men are required to write a letter to themselves, as if they were their victim, describing how she felt and the effect the offence has had on her life. Then in phase two, the offence cycle, they will break down all the events, feelings and thoughts that led up to the crime. In stage three, they will describe the offence, and the rationale for it, in more detail and address "cognitive distortions." In other words, they will examine ways they have rationalized the crime, be it by assuming the child "has liked it," or is capable of consenting to sex with an adult. After completing all three steps over a year and a half, stage four will be follow-up — ongoing therapy as is required.

While observing the group, it becomes clear that therapy for sex offenders does not help people to change their sexual desires, even when these urges are directed towards prepubescent children. (As social worker Julie Zikman later explains, "They [sex offenders] can learn behaviours and fantasies to avoid, but that doesn't change their desire.")

Although sex offenders don't usually have a major mental illness, they may suffer from low self-esteem and difficulties with assertiveness. In this group, the voices are soft-spoken, the references to sexual incidents almost prudish. We could be at a social skills group with a bunch of lonely, disheartened men seeking better relationships with their family and friends: they describe their struggles to maintain marriages and jobs in the wake of embarrassing incidents that have brought a buried secret, startlingly, to the surface.

The man who presents his "offence" today appears to be showing genuine remorse for what he's done, and has accepted responsibility for his crime — both factors that are known to reduce risk of reoffending. (Other predictors of relapse include the offender's relationship to the victim; the victim's gender; the offender's criminal record, and history of prior sexual offences, including age at time of first offence; and having a drug problem or an antisocial or psychopathic personality.) Psychopaths — who are characteristically impulsive, manipulative and unempathic — generally do not respond well to treatment. Many will deny ever having committed the crime, which may preclude them from even being accepted into treatment.

In the next stage of the program, relapse prevention, these men will develop an even more detailed list of potential risks for reoffending, and how they can be avoided. This list may include not visiting a certain place (such as a park or schoolyard) and dealing with feelings (such as boredom) that they have identified as preceding prior offences.

Then only time — years — will tell if the treatment has been successful. ■



Devices used in a phallometric lab

Meditating behind bars

BY TAMSEN TILLSON

A very hard life leaves its mark on a person's face. Years of alcohol or substance abuse mar the features, and the scars that violence carries are often literal. But more than anything, a life of struggle and tragedy shows up in the eyes. They're veiled, saddened, angry, hopeless.

You can see it on the faces of seven women serving time at King County Jail in Seattle, Washington. These seven have been in and out of jail many times, for crimes such as theft, prostitution, drug dealing, assault and shoplifting. They have problems with alcohol or substance abuse. And they are the subject of a documentary called *Changing from Inside*, in which they complete a 10-day Vipassana meditation course provided by the North Rehabilitation Facility at the prison.

"I love myself today," says one woman soon after completing the course, tears spilling from her eyes and coursing down her cheeks. "These are tears of happiness...things I'd been running from all my life, it was just right there in my face, I had to look at it, observe, and let it go... and there's such a peace and such a weight lifted, I can't tell you."

King County may be the only jail in North America that offers Vipassana courses, but there are a number of groups in the United States that offer meditation, breathing exercises and/or yoga to prisoners. Tom Duffy, a former housepainter who struggled with addiction and dabbled on the wrong side of the law, was himself transformed when he discovered meditation and yoga. In 1992 Duffy set up a foundation called Prison SMART (Stress Management And Rehabilitation Training). In five to 10-day training courses provided through the Art of Living Foundation, Prison SMART teaches breathing techniques to prison inmates, residents of halfway houses, those on parole and probation, at-risk youth, victims of crime, law enforcement officers and probation staff across the United States. "It's all about smart ways to stay out of jail, and also smart ways to make the time spent in jail productive," says Duffy. There are currently 14 Prison SMART programs offered across North America.

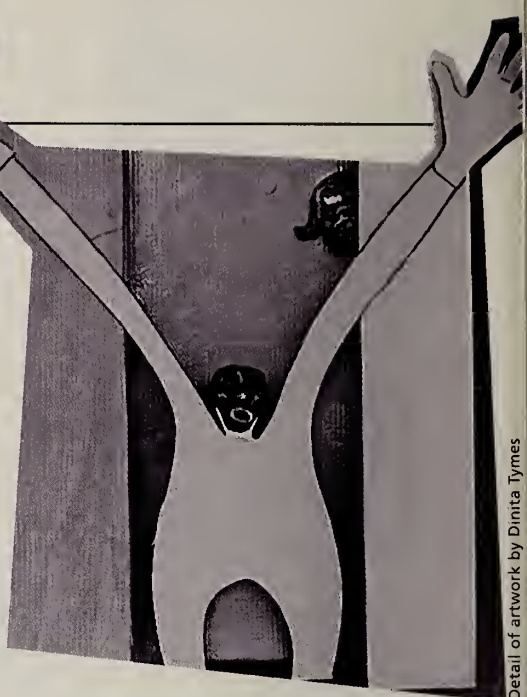
The ancient tradition of meditation for dealing with addiction, stress, anger and depression has been taught in prisons in India on a regular basis since the early '90s, but is moving more slowly into North American jails. The North Rehabilitation Facility is itself an unusually progressive place. "We're very intensive about programming," explains facility administrator Lucia Meijer. With remedial education, computer training, chemical dependency treatment, acupuncture and life skills among the courses available, "we were already going in that direction," she says. Then three years ago nurse practitioner Ben Turner suggested they try a Vipassana meditation course at the centre. "My initial thought was, we have all kinds of volunteer activities, and if someone wants to come in and teach someone to reduce their stress, great," recalls Meijer. She concedes that she did not know much about meditation. "I do not run with the wolves."

Vipassana courses are highly standardized—in prison or out, the ancient Indian practice requires 10 days of isolation, "noble silence" and special food. But Meijer was convinced after she tried it herself. It was among the toughest things I have ever done," she says. "I understood how important this would be, particularly for anybody in habitual negative thinking and behaviour, and especially for those who are antisocial. I thought, we really have to give this a try."

Prison staff were also enthusiastic, but skeptical as to how many would be interested in a "mental boot camp" without incentives, one that required the foregoing of all privileges. Run by volunteers, the participants start their days at 4 a.m., and engage in silent meditation for 10 hours a day, focusing on breathing, concentrating on the sensations that pass through their mind and body. Meijer calls it a "mental detoxification process."

Sixteen men signed up for the first course, held in the fall of 1997. Nine of them completed it. "I couldn't believe the change I had seen in the men who'd done it," says one of the women in the film who later took the course herself.

Moving as the testimonials and photographs of those who have gone through the course are,



Detail of artwork by Dinita Tymes

the benefits of meditation have to be quantified before it can be floated as a viable option in the North American prison system. In total, 62 men and 21 women have taken the course at King Country Jail. Anecdotal, Meijer notes that those coming out of the courses tend to be much easier to work with, with fewer behavioural problems. And in the short term at least, recidivism is lower.

"In terms of getting someone prepared for recovery from addiction," opines Meijer, "it's an excellent tool. Because it takes you right to the root of the addiction, because we're not addicted to the drug, we're addicted to the experience when we take the drug...and that's what you're dealing with when you do this meditation."

Alan Marlatt, a psychology professor at the University of Washington, is currently heading up a project to evaluate the short-term and long-term effects of the Vipassana program, both for inmates still incarcerated and as a follow-up once those who've tried it are released. "What's clear is that this has an amazing impact on the people who go through it," he explains. "What we're trying to do is capture that and objectively measure what these people are saying." He hopes to have some short-term results available by the end of the year. ■

For more information about *Changing from Inside*, or to order a copy of the video, please contact: University of California Extension, Center for Media and Independent Learning, 2000 Center St., 4th Fl., Berkeley, CA 94704, tel (510) 642-0462; fax (510) 643-9271, e-mail <cmil@uclink.berkeley.edu> <http://www-cmil.unex.berkeley.edu/media/>.

Training cops to be more sensitive

BY GAIL DUGAS

IT WAS AN EMERGENCY ROOM VISIT GONE TERRIBLY WRONG. Last December, a 46-year-old trucker went to Langley Memorial Hospital in B.C. complaining of pain and anxiety. While being kept for observation, he began yelling and threatening people, wielding a pair of surgical scissors. Nine hours later he was shot dead by an RCMP officer after the trucker allegedly came after him. There will be an inquest into the case.

"We get called to the ER at least 30, maybe 40 times a year," says RCMP Cpl. Delaney Fraser, the officer in charge of training for the 146-member Langley detachment. "We knew this was serious. We didn't send rookies. We sent three officers with years of experience."

The veteran officer who fired the shot did have years of experience under his belt. But the detachment does not provide any special training for officers dealing with patients with psychiatric problems. The Fraser Valley Mental Health Unit has offered seminars for the officers. But so far the offer hasn't been accepted. The problem in Langley raises a more global concern – the importance of ensuring a consistent, minimum amount of crisis resolution for all police. This reflects one of the many recommendations made by the coroner's inquest into the 1997 police shooting of Edmund Yu, a man with schizophrenia.

Last March, Toronto's Police Service reinstated a revamped crisis intervention course that had been dropped several years earlier due to budget cuts. Public pressure and the Yu inquest recommendations convinced the department to step up training.

"The course has been redesigned to better equip officers to handle all emotionally disturbed persons, particularly those who are mentally ill, by using communication and crisis resolution techniques," says Sgt.

Scott Weidmark, the officer in charge of training for the Toronto force. "The whole focus of the [50-hour] course is de-escalation of potentially violent situations."

"Scott gets it, but thousands of others don't," says

Lana Frado, executive director of a psychiatric survivor peer support group. Twice a week, Frado gives training seminars to Metro Toronto Police officers. She says a basic error many police make is to start a conversation by asking people "if they are taking their medication. They think they are doing the right thing by asking," she says. "It is news to them that it pisses you off if you are mentally ill

and someone asks you that." And she says it saddens and angers her to hear police officers make fun of the mentally ill.

Figures from 1998 show that Toronto police apprehended 1,176 people considered suicidal and 2,466 people who were endangering themselves or others. But Weidmark says that this is a small percentage of the tens of thousands of situations his officers encounter involving people

with serious psychological and addiction problems.

Under the new training regime, officers are taught to recognize and deal with the mentally ill. "If someone is hallucinating, you don't want to argue the hallucination because right now you are that person's only link to reality, and it is your job to investigate the hallucination, use empathetic listening techniques and communicate and create a rapport so that they will tell you what the problems are."

However Weidmark admits that that is a tall order. "Police officers are hired because they want to get things done when they arrive on the scene," he says. "It is a matter of pulling the reins on them and saying

'Hey, there's a better way of doing this.' Really our goal is to try to take a pro-active approach and try to get other groups to help these people."

As professor of psychiatry and criminology at the University of Toronto, Chris Webster spends a lot of time training mental health workers and talking to police officers. He stresses the importance of police having a phone number they can call to quickly reach mental health professionals. "The decisions that are made at the

front end are critical. If problems there are not diffused, then a mentally ill person can quickly get drawn into the legal system and stay there unnecessarily for quite a minor infraction." He says officers should be aware that people with a mental illness are only slightly more likely to be violent than someone from the general public. Although he knows that uniformed officers are necessary, "sometimes you send in an armed police officer, who may be compassionate and well-trained, but it is the uniform itself that can sometimes make the situation worse."

In Hamilton, it was a series of tragedies and inquest recommendations that prompted a change in training for the 700 members of that police force. It also prompted the creation of a Crisis Outreach and Support Team (COAST), two plain-clothes police officers working with mental health specialists. COAST members regularly participate in "parades," the briefing and instruction time at the beginning of a police shift.

"We find officers listen when... front-line people like themselves, people who know the Hamilton situation," are doing the talking, says Staff Sgt. Tony Belisario, officer in charge of training for the force. While other forces across the province offer mental health training as an elective, in Hamilton it is mandatory.

That pleases Ron Hoffman, the man who developed the course. "You can always do more, I guess," he says. "How do you know what enough is? But I am confident that we're hitting the right material." ■



Detail of artwork by Dinita Tynes

Q & A

Common questions about Smart Reform: Treating offenders with more compassion

What is the prevalence of mental health and addiction problems in jails?

A random sample of 1,925 male, federal inmates revealed a high prevalence of mental health problems. Almost seven per cent had a psychotic disorder, 57 per cent had antisocial personality disorder, 44 per cent had an anxiety disorder and 21 per cent had a depressive disorder.

However rates for women inmates differ. While it is more difficult to provide percentages on women (since female offenders are less common, particularly when it comes to committing violent crimes,) some generalizations can be made. Incarcerated women are more likely than their male counterparts to be depressed, to have borderline personality disorder and to have experienced physical or sexual abuse, sometimes leading to posttraumatic stress disorder.

A 1991 report, based on a study of 503 federal male offenders, revealed that more than 30 per cent used substances at least a few times per week in the six months prior to being arrested. The study also indicated that violent offences are more likely to be committed under the influence of alcohol or both alcohol and other substances, rather than substances alone. Robbery, on the other hand, is associated more with the use of substances other than alcohol.

Because of urinalysis tests being implemented in prisons, inmates are now more likely to be using heroin than marijuana: heroin clears faster from the urine, and is thus less likely to be detected.

Are people with mental health problems treated differently by the criminal justice system?

People with mental health problems are often diverted from the criminal justice system – be it because they are considered unfit to stand trial, found not criminally responsible or viewed as unlikely to benefit from incarceration.

However once the mentally ill are taken into the criminal justice system, they are treated with extra caution. Male offenders with serious mental health problems may get fewer chances for early release on full parole, and may be more likely to have their release revoked without committing another offence, according to studies. This points to an inherent bias within the penal system towards people suffering from mental health problems.

How do mental health problems affect chances of reoffending?

Risk factors for criminal behaviour (violent or non-violent) are almost identical for people with mental health problems as for those without. The behaviour is predicted by criminal history, age (youth), having antisocial peers and substance abuse problems. Interestingly, people with a drug abuse problem are more likely to be violent than those who abuse alcohol. In the United States, opiate addictions pose a slightly higher risk than alcohol.

However the only significant predictors of general recidivism (being arrested or returned to hospital for criminal behaviour) are having a history of psychiatric admissions and antisocial personality disorder. According to a 1991 Penetanguishene report, there is close to an 80 per cent chance that psychopaths will reoffend in the 10 years following their release.

While having a mood disorder such as depression bears no relationship to reoffending, having a severe mental health problem, such as schizophrenia, is actually inversely related. This is because violence committed during a psychotic break tends to be an episodic, transitory occurrence; this is quite unlike an offender who, with full sanity, and entrenched attitudes commits a pre-meditated crime.

How much treatment is available to people in jail with mental health or addiction problems?

Within federal penitentiaries, there are living skills programs available to inmates – involving everything from addiction treatment to cognitive skills programming, parenting, and anger and emotion management. While inmates can refuse to participate in these programs, this will affect their chances of early release.

Part of treating criminal behaviour involves treating the substance abuse problem that often accompanies it. Substance abuse programming in federal penitentiaries is graded in terms of level of intensity, from educational sessions (for drug traffickers or less serious users) to an Offenders Substance Abuse Pre-release (OSAP) Program that involves three hours per day for six weeks, or what is equivalent to a 28-day program in the commu-

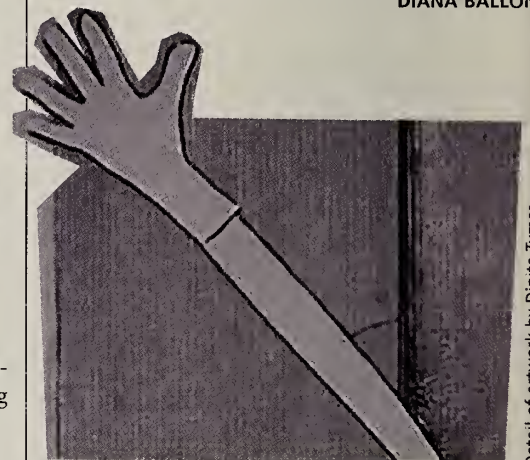
nity. OSAP was first piloted in federal penitentiaries in the mid to late-eighties, and is now used at Canadian penitentiaries. Also available is the Choices Program, an addiction program which is offered nationally for released inmates in the community.

How do people end up on a forensic unit?

In 1992, the law was changed, making it easier to place people on “disposition orders,” either for being unfit to stand trial, or as is more commonly the case, for being found not criminally responsible by reason of mental disorder. Thus many people with less serious offences, and an accompanying mental health problem, are now considered forensic clients.

Treating forensic clients for mental health problems can be difficult, given that psychiatric problems are often varied, and that forensic units tend to define clients by their legal versus mental status. A mental health problem is often compounded by an addiction, while it is the addiction – rather than the psychiatric problem – that tends to lead to violence and other criminal behaviour.

DIANA BALLON



Detail of artwork by Dinita Tynes

Sources: Dr. Howard Barbaree, clinical director, Law and Mental Health (formerly the Forensic) Program, CAMH; Chris Webster, professor of psychiatry and criminology, University of Toronto; Lynn Lightfoot, consulting psychiatrist, Correctional Services Canada; Grant Harris, research psychologist, Mental Health Centre at Penetanguishene; Karl Hanson, senior research officer, Corrections Research, Dept. of the Solicitor General of Canada; The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis, *Psychological Bulletin*, 1998, v. 123(2), 123–142 Correctional Service of Canada Research Reports: *Evaluation of Correctional Service of Canada Substance Abuse Programs*, 1991; *The Prison Careers of Offenders with Mental Disorders*, 1992; *Female Offenders With and Without Major Mental Health Problems: A Comparative Investigation*; *The Prevalence, Nature and Severity of Mental Health Problems among Federal Inmates in Canadian Penitentiaries*, 1991; *Patterns of Alcohol and Drug Use Among Federal Offenders as Assessed by the Computerized Lifestyle Screening Instrument*, 1991.



Poetry from the Edge

IT HEARTENS ME THAT POEMS ARE written. That in spite of the mad dash to accumulate and consume, holy moments of living are distilled into language by poets who often work in isolation, compelled by some wild faith.

It heartens me too that poems are published – that poems matter. That I can open a book and read:

Life with schizophrenia
Is cops at your door
Because you've called 911
To report that your friend's in trouble.
Then you have to say
You found out
Through telepathy

This verse is from a poem called 'Symptoms' by Elizabeth MacDowell, and is included in the collection *If I Played My Life: Poems by people with schizophrenia*. Nervy and original, *If I Played My Life* features the work of 20 poets and is charged with the everyday polarity of

despair and hopefulness that accompanies living with a chronic illness. That this body of work exists at all is testament to triumph over tribulation; in particular, triumph over the demands mental illness and its treatment make on people and their ability to express themselves in a creative and cogent manner.

The book is divided into several sections, loosely organized around such themes as coping with the illness, living a medicated life, the reaction of family and friends to schizophrenia, and finally, attempts at clarity and healing. As is often the case with collections that feature the work of several artists, the quality of the writing is uneven from one piece to the next, and sometimes, within the same piece. Some of the poems are funny: others, sobering. Some are wistful recollections of better times: others, quiet resignations of dashed wishes. Here and there a line vibrates with naked honesty, or a title evokes a snicker of recognition. And some otherwise unremarkable poems are embedded with whole sequences that burn with rage and desperation.

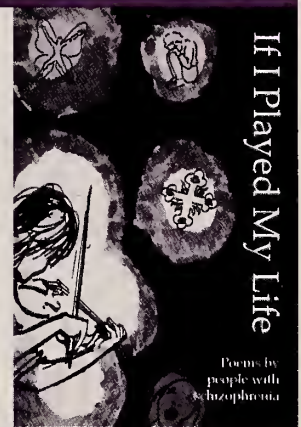
As for the book itself, it's elegant and pleasing to touch and hold. In evidence are the care and

deft craftsmanship that infuse the design, layout and typography. If I have any gripe at all, it is with the editor's decision to arrange the poems by a loose linking of topics rather than by author. The seemingly haphazard placement deprives the reader of a complete sense of one poet's voice.

Also, biographical sketches of contributors – a regular feature of anthologies – are noticeably absent as endnotes. This absence subtly emphasizes the invisibility of and the stigma against people with mental illness. And the omission left the impression that the book, in spite of its many virtues, was somehow incomplete.

LISA SCHMIDT has written book reviews for *Quill and Quire*, *Canadian Forum*, *Our Times* and several Canadian literary magazines.

If I Played My Life: Poems by people with schizophrenia, ed. Kate Goldsmith, Bayeux Arts Inc., 1998, 112 pp., \$9.95.



Stopping time with Heroin

HOW TO STOP TIME: HEROIN FROM A to Z is part memoir, part meditation on the consumption of heroin in our consumer society, part snapshot of a time when New York City was home to all the truly cool rock bands and everyone in the scene snorted heroin, including author Ann Marlowe. Harvard-educated with a high-paying Wall Street job, Marlowe does not sound like a typical user. Yet this is precisely what makes her book so interesting.

Marlowe's book does not offer any patronizing "don't do it" messages, or any dramatic "kicking dope" tales. Instead, she talks about how she used drugs to "stop time," to shelter herself from the need to take personal risks or experience change. For Marlowe, "dope was a home... providing a predictable comfort and security." Yet that comfort and security came to be seen only as an illusion of completeness: "After I quit, it gradually came to me that the messy stuff I'd been screening out with dope – the nitty-gritty of having a relationship, constructing friendships, getting along with acquaintances, meeting new people... was in

fact the only material life presents."

Marlowe is not ashamed of endangering her body or letting anyone down. She's pissed off at herself for wasting time on the isolating, predictable routine of using, recovering and buying – and not realizing that she was doing it: "[T]he love of predictable experience, not the drug itself, is the major damage done to heroin users. Not getting on with your life is much more likely than going to the emergency room, and much harder to discern from the inside."

Marlowe's drug use is presented as a negative reaction to a society in which it is almost impossible to simply live in the moment: where working is accepted as the highest good, purchasing power is the great reward, and being productive is a constant demand. "Sports are supposed to be about cardiovascular conditioning and muscle building. Yoga is to relax so we can work more productively. And so the purely fun becomes the useless, or even the harmful."

Yet instead of truly rejecting the trap of working or buying, Marlowe describes how using heroin becomes the most extreme manifestation of consumer society. Both buying things and

using heroin are ways to achieve a sense of completeness, a sense of wanting for nothing. "Centering your life around copping [buying heroin] is not so different from centering your life around shopping, or making deals. Same activity. Different aesthetic."

Marlowe knows that talking directly about the evils of consumerism is not particularly interesting. But give it the hook of self-destructive heroin use and people will take notice. "Our culture has lent dark powers to narratives of drug use, more than to drug use itself, and I am taking advantage of them, like a painter using the severity of northern light." Rarely is the use of drugs itself taken seriously as an activity that needs to be understood in its fullest context, not moralized about. Marlowe's book is one step in the direction of gaining such an understanding.

ANDREW JOHNSON is a product developer for the CAMH, and a Toronto writer and editor.

how to stop time: heroin from A to Z, Ann Marlowe, Basic books, New York, 1999, pp 297, \$36.50 HC.

The Last Word

The **ethics** of working for the **alcohol industry:** a personal view

The research community has not come to a consensus on the ethics of accepting money from the alcohol industry. On the one hand, some researchers hold that industry sponsorship automatically undermines scientific credibility. On the other hand, some hold that industry funding can be accepted provided there are safeguards to scientific integrity. One of the key safeguards is transparency: everyone would agree that industry sponsorship should always be openly acknowledged and never hidden.

I have conducted a number of small projects supported by alcohol producers. For example, I helped organize a conference funded by Labatts on the role of medical education in alcohol prevention that led to increased attention to alcohol issues in Canadian medical schools. I authored chapters in books published by the industry-sponsored International Center for Alcohol Policies (ICAP) in Washington, D.C., and participated in two ICAP conferences. Twice annually I attend meetings of the Brewer's Association of Canada's Alcohol Advisory Panel along with 10 other public health representatives.

I have my own personal rules regarding working with alcohol manufacturers. First and foremost, the work must be in the interests of public health. For example, I won't conduct research to help market alcohol, but I'm more than willing to help make their prevention programs more effective. But defining whether an activity is in the interests of public health is a subjective judgment, as no external standard exists. In my view the major criterion is the impact of the collaborative activities on drinking behaviour and alcohol-related problems. Industry initiatives often involve a dialogue between industry and public health representatives on alcohol issues. Industry representatives frequently solicit critical comment on their prevention programming. If I felt that industry was not acting upon the suggestions of public health representatives, I would not participate in these dialogues.

In some cases, public health representatives take the initiative in proposing industry actions to reduce alcohol-related problems. For example, two years ago I challenged ICAP about inadequate consumer awareness of alcohol content in products. I noted that since the industry claims that drinkers should be treated as responsible persons and less subject to paternalistic controls, the industry has an obligation to provide consumers with the information required to make responsible choices. As a result, ICAP arranged a special meeting to promote efforts to better inform drinkers about the alcohol content of different products. And some manufacturers have voluntarily instituted standard unit labelling on their products.

I also take care not to become dependent on industry income. I haven't set a specific limit, but the modest honoraria I receive for industry-sponsored activities have never been more than two per cent of my annual income.



BY ERIC SINGLE

(Some researchers like myself do not hold salaried positions. It is one thing to refuse an honorarium when you're already being paid a salary, and quite another thing to donate your time entirely without compensation.)

Finally, I always insist that any works sponsored by the industry be open and public. If possible, industry sponsorship should be at arm's-length (e.g., via an independent peer review process, such as that of the Alcoholic Beverage Medical Research Foundation). This helps to insulate projects from industry influence.

I understand why some of my colleagues are strongly opposed to working with the industry. There are threats to scientific integrity in working for any client, even government, if one doesn't take precautions. There is a danger that the industry might use the research and prevention projects it sponsors, including the names of eminent public health collaborators, for public relations purposes or to promote increased consumption. Without appropriate safeguards, alcohol producers could manoeuvre themselves into having a de facto veto over actions by public health partners in joint endeavors.

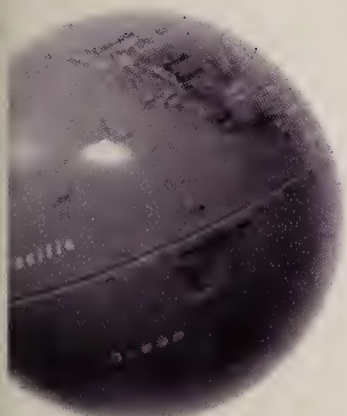
Nonetheless, I believe that one can accept funding from the industry without necessarily compromising scientific integrity. Effective prevention is not only in the interests of public health; it is also in the economic interests of the alcohol industry. Unlike tobacco, alcohol consumption entails not only adverse consequences but also significant health benefits. Furthermore, the alcohol industry has not generally behaved in the repugnant manner typical of the tobacco industry.

In my view there will be increasing co-operation between public health and the alcohol industry in the foreseeable future. In part this is because the relative importance of industry funding has increased as government funding has decreased. Current government investment in alcohol research is woefully inadequate, particularly in light of the huge revenues generated by alcohol. More importantly, the emergence of compelling evidence that alcohol use has significant cardiovascular benefits has important implications for the relationship between public health and the industry. The message in alcohol prevention can no longer be simply that "drinking less is better." For some, a modest increase in drinking may actually be in their best interests. The key message is changing to "avoid problems when you drink." New prevention measures focus on environmental modifications and preventing intoxication rather than convincing all drinkers to reduce consumption. As such, there is a great deal more leverage for public health and the industry to work together. Time will tell if this is to their mutual benefit. ■

Eric Single, PhD, is professor of Public Health Sciences at the University of Toronto, research associate for the Canadian Centre on Substance Abuse, and president of his own consulting firm. He has researched addiction issues for more than 25 years.

Editorials do not necessarily reflect the views of the CAMH. We welcome submissions from our readers. For information, contact: The Editor
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33 Russell St., Toronto, Ontario M5S 2S1
tel.: (416) 595-6714
e-mail: <journal@camh.net>

Conferences



CANADA

First Conference on Healing Sexual Exploitation and Prostitution

May 4-6, Edmonton, Alberta.
Contact: tel (780) 497-5188,
e-mail <a2a2000@gmcc.ab.ca>,
web <http://a2a2000.gmcc.ab.ca>.

Dialogue on Concurrent Disorders: Clinical Applications in Substance Abuse and Mental Health

May 5, Ottawa, Ontario.

Contact: Pamela G. Mitchell,
P.G. Mitchell & Associates Inc., 174
Oakridge Blvd., Nepean, ON K2G 2V2,
tel (613) 225-1435,
fax (613) 225- 0130.

Community Mental Health and Addiction Conference 2000

May 6, Toronto, Ontario.
Contact: tel (416) 603-5974,
fax (416) 603-5049,
e-mail <Adelia.Cerqueira@uhn.on.ca>.

Assistance 2000 – Employee Assistance Program Conference

May 10-12, Lesser Slave Lake, Alberta.
Contact: Northern Lakes College, 1201-
Main Street, S. E., Slave Lake, AB T0G 2A3,
tel (780) 849-8623,
fax (780) 849-2570,
e-mail <mackenzie@yourfuture.ab.ca>.

Prairie Province Conference on Fetal Alcohol Syndrome

May 11-13, Winnipeg, Manitoba.
Contact: 2000 Manitoba Conference on
FAS, Manitoba Children and Youth
Secretariat, 100-233 Portage Avenue,

Winnipeg, MB R3B 2A7,
tel (204) 945-2266,
fax (204) 948-2585,
e-mail <childrenfirst@cys.gov.mb.ca>.

Ontario Hospital Association: Mental Health Conference

May 15, Toronto, Ontario.
Contact: Ontario Hospital Association,
200 Front Street West, Suite 2800,
Toronto, ON M5V 3L1,
tel (416) 205-1362,
e-mail <programs@oha.com>,
web <www.oha.com>.

Ontario Federation of Community Mental Health and Addiction Programs: Annual Conference and AGM

May 22-26, Toronto, Ontario.
Contact: Janet Chui,
tel (416) 490-8900, ext. 27.

National Conference on Women and HIV/AIDS

May 25-28, Toronto, Ontario.
Contact: The Events Team, Canadian
AIDS Society, 900-130 Albert St.,
Ottawa, ON K1P 5G4,
tel 1-877-998-9991,
fax (613) 563-4998,
e-mail <women@cdnaids.ca>.

30th Annual Meeting of the Jean Piaget Society: Society for the Study of Knowledge and Development

June 1-3, Montréal, Quebec.
Contact: Dr. Cynthia Lightfoot, Jean
Piaget Society, Penn State Delaware
County, 25 Yearsley Mill Road, Media,
PA 19063-5596, USA,
web <www.piaget.org>.

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(Jim Milligan and Janice Hambley as discussants)

Prevention and Health Promotion: Irving Rootman
(Diane Buhler and Andrea Stevens Lavigne as discussants)

Policy: Eric Single
(Robert Solomon and Diane Riley as discussants)

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For further information or to receive conference information, please contact Allen Flaming at (416) 977-5580 or by e-mail aflaming@ontario.cmha.ca or Lianne McKay at (416) 535-8501 ext. 4253 or by e-mail lianne_mckay@camh.net

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Thamesville, Ontario N0P 2K0

e-mail: homeoffice@westover-fdn.org

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North American Syringe Exchange Conference (NASEC)

April 26-29, 2000, Portland, Oregon.

Contact: NASEN, 535 Dock St., #112,

Tacoma, WA 94802,

tel (253) 272-4857,

fax (253) 272-8415.

SALIS: Substance Abuse Librarians and Information Specialists

AOD in Y2K and Beyond: Back to the Future of Alcohol and Other Drugs

May 3-6, New York, New York.

Contact: SALIS,

e-mail <salis@arg.org>

web <http://salis.org>.

American Psychiatric Association Annual Meeting

May 13-18, Chicago, Illinois.

Contact: American Psychiatric

Association, Office to Coordinate Annual

Meetings, 1400 K Street, NW,

Washington, DC 20005,

tel 1-888-35-PSYCH, or (202) 682-6237,

fax (202) 682-6345,

web <http://www.psych.org/sched_event

/ann_mtg_00/index.html>.

ABROAD

15th International Conference on Alcohol, Drugs and Traffic Safety

May 22-26, Stockholm, Sweden,

Contact: Nyman & Schultz AB, Box 1326,

SE-111 83, Stockholm, Sweden.,

tel +46 86 98 04 90,

fax +46 87 91 85 84,

e-mail <specialprojekt@nymans.se>,

web <www.ICADTS2000.com>.

Psychology After the Year 2000

June 12-14, Haifa, Israel.

Contact: Psychology Conference, c/o

Comtec, P.O. Box 68, Tel-Aviv 61000, Israel,

tel +972 3 5666166, fax +972 3 5666177,

e-mail <conferen@psy.haifa.ac.il>,

web <http://psy.haifa.ac.il/conference>.

2000 Winter School in the Sun and IFNGO Conference

July 3-6, Brisbane, Australia.

Contact: Alcohol and Drug Foundation

tel 07 3832 3798,

web <www.adfq.org>.

2nd International Congress of Licensure, Certification, and Credentialing of Psychologists

July 18-20, Oslo, Norway.

Contact: Norwegian Psychological Ass.

fax +47 22 42 42 92,

e-mail <npfpost@psykol.no>.



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Number 4

PERIODICALS READING ROOM
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sexuality

**Sexual side-effects
a turn-off**

**Sex on a
psych unit**

**Gay teens
feel isolated
and alone**

**Drinking beliefs
result in risky sex**

A FRAGILE REVOLUTION

How "ex-mental patients" have transformed themselves into consumer/survivors

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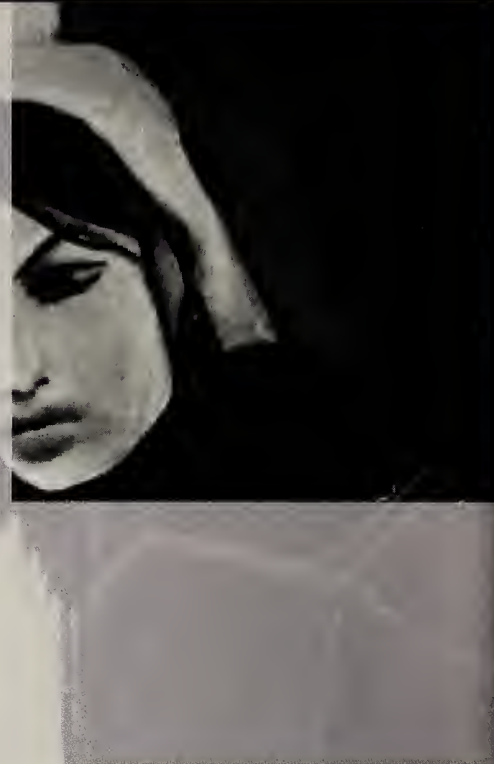
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Cover

Peeled (detail)
Kimberly Martin
Acrylic on canvas
36" x 48"



"My inspiration for *Peeled* came from shedding
my old self and being reborn," says Kimberly
Martin, a Toronto artist. To purchase her work,
contact the Adelaide Resource Centre for Women
at (416) 392-9292.

Centre Update

Many parts of the world have witnessed an emotionally charged debate over the costs and benefits of gambling. Although most people who gamble do so without harming themselves or others, a minority do experience serious personal, social and financial problems. In most countries where the prevalence of problem gambling has been studied, three to five per cent of the population show signs of some gambling-related problem. The good news: there is growing acknowledgment that all levels of government, the gaming industry, health care and social service providers and other allied professional groups have a responsibility to help those people who are negatively affected by gambling.

For more than six years, the Centre has been involved, through its founding partners, in problem gambling research, treatment and education. The Problem Gambling Project is a program that provides training and support materials on issues related to problem gambling for Ontario's designated problem gambling treatment system, allied professionals and communities. The following are three particularly innovative resources:

The Promoting Community Awareness of Problem Gambling Resource Package is designed to support treatment agencies' community-based work in public awareness and professional education on gambling and problem gambling. Its goal is to equip local agencies with the tools and resources they need to reach key audiences with information that will increase understanding of problem gambling, to encourage individuals to seek help and access support. Earlier this year, more than 100 staff from the 44 designated treatment agencies in Ontario attended training sessions in five communities. Participants responded very positively to the package and the training. The Centre is now looking at opportunities to make this resource available in jurisdictions outside of Ontario. For further information, contact Robert Murray at (519) 743-1939.

Helping the Problem Gambler provides practical information on the nature and dynamics of gambling problems and how to help problem gamblers and their families. It is designed to increase understanding and empathy for those affected by gambling problems and to help develop relevant counselling skills aimed at reducing or eliminating the harm caused by gambling. This resource is intended not only for counsellors who work in Ontario's designated problem gambling treatment system, but also for clinicians in the addiction system who want to help clients experiencing gambling-

Note from the Editor

For the cover of this issue, we chose an abstract image by Kimberly Martin to convey sexuality – because ultimately it is something personal, individually defined and varied in its expression. We are fortunate to have several other pieces of her artwork interspersed through the focus section. Although Martin began painting seriously less than a year ago, she has produced a wide body of work, and recently garnered the City of Toronto Frankly Bob award for painting.

The stories in our focus section only begin to touch on the many issues influencing a healthy expression of sexuality. Angela Pirisi's story about the sexual side-effects of antidepressants focuses on the strictly physical: on sexual dysfunction as a symptom of even the newer medications. In contrast, Andrea Gordon's piece on gay teens examines the emotional response of adolescents struggling to come to terms with their homosexuality – amid a mainstream culture that often stigmatizes difference. Tamsen Tillson's story about "sex on a psych unit" raises another critical issue – how to redress a climate that has historically ignored the sexuality of psychiatric clients, much like the situation for people with developmental disabilities.

A story on the VALIDITY ♀ (Vibrant Action Looking into Depression in Today's Young Women) Project explores how Danah Beaulieu lived through depression and has gone on, with great passion, to work with other young women for change. I assigned this piece as a first-person story because I didn't think that it could be told through standard reporting. Because ultimately it's a story that goes beyond facts: it's about women's perseverance, strength and ultimate optimism – in spite of depression.

As I wander along the streets, and through the market, I am struck by how much happier people seem now than during the depth of winter. Do we all, on some level, suffer from seasonal affective disorder? Or has warmth and light simply softened our outlook?

We deal with a lot of heavy subjects in this journal and, for many, in our day-to-day lives. With long, sunny days, no doubt we can all benefit from a certain "lightness of being."

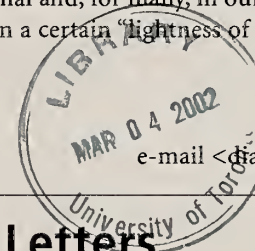
Wishing you a very happy summer.



DIANA BALLON

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related problems. For further information, contact Robert Murray at (519) 743-1939.

Developed in partnership with the North American Training Institute, **Red Flags & Referrals** is a resource designed specifically to reflect the responsible gaming needs of the Canadian gaming industry. This kit gives gaming and wagering employees an understanding of their corporation's responsible gaming mission and problem gambling, along with information about community referral resources.

This multi-media CD-ROM PowerPoint presentation provides gaming corporations with a responsible gaming training kit that can be efficiently implemented by in-house company staff. For information, contact Marketing & Sales Services, 1-800-661-1111 or in Toronto, (416) 595-6059.

For further information on other areas of CAMH's efforts in problem gambling, visit <www.camh.net> and the *Electronic Journal of Gambling Issues* at <www.camh.net/egambling/index.html>.

CHRISTA HAANSTRA

Letters

Shakespeare and the "noted weed"



Most readers know that the plays and poems of William Shakespeare (1564–1616) contain a multitude of topical allusions. However, a recent reference to the Bard and the "noted weed" was unexpected.

In his review of W.H. Auden's *Lectures on Shakespeare* (*Times Literary Supplement*, March 23, 2001), Robert Craft refers to the recent discovery of "cocaine, cannabis and myristic acid (a plant-derived hallucinogen)" in clay pipe fragments excavated from Shakespeare's home in Stratford on Avon.

In addition to "noted weed," Sonnet 76 also refers to "...new-found methods and to compounds strange?" Would some of your scholarly readers care to speculate on the relationship between this somber sonnet and the use of recreational drugs in Shakespeare's time?

Dr. Cyril Greenland
Professor Emeritus,

McMaster University School of Social Work

In Brief

Is your teen getting enough sleep?



Adolescents who don't get the recommended nine hours of sleep per day may become depressed. Though the link between depression and a lack of sleep among teens appears repeatedly in research, sleep is often ignored by teens, according to Mary Carskadon, a sleep specialist at Brown Medical School in Providence, Rhode Island, as quoted in a *Toronto Star* article. Kids are often taught from early on that staying up late is a reward, while negotiating bedtime frequently becomes a way to assert their independence: the result being that adequate sleep is compromised. Even if adolescents are aware of their need for sleep, little support exists for them to figure out how to get it.

Pedophiles open to scorn

Within limits, it's now fair game to ridicule and deride pedophiles on the nation's airwaves. The Canadian Broadcasting Standard Council ruled that the Canadian Association of Broadcasters' code of ethics provides no protection for pedophiles from discriminatory comment based on mental handicap, according to an article published in *The Globe and Mail*. The ruling stemmed from a complaint about a comment made on The Comedy Network's *Open Mike with Mike Bullard* to the effect that a serial killer who targets pedophiles was performing a public service. The human-rights provision's purpose is to protect people from biased comments about who they are, rather than what they do – such that unlawful actions, even by people with mental illness, are not protected.

Mexican drug museum may go public

Bottled crack cocaine, a turnover filled with marijuana and photos of a woman's buttocks implanted with cocaine are some of the items that may be on public display at a Mexican Defense Ministry museum. Relics of the country's war on drugs, the paraphernalia is shown to police and soldiers to give them a sense of what they're up against as they prepare to join the fight on the front lines. Ever since a profile of the museum was aired on Mexican television, it's been besieged with requests for public tours. Authorities are concerned that public access to the museum might allow smugglers and criminals to compare strategies and better their illegal practices, according to Associated Press.

Separate shelters considered for transsexuals

The City of Toronto is considering a plan to create separate homeless shelters for transsexuals. Regular shelters are considered inappropriate for the city's estimated 100 homeless transsexuals, most of whom are men hoping to become women, reports the *National Post*. Though considered a discriminatory action by some, many women's shelters are reluctant to or won't take pre-operative transsexuals for fear of disturbing the shelter's environment. The Ontario government's 1998 decision to discontinue paying for sex-change operations is considered partly to blame, as it has left many transsexuals in a gender "limbo" without the financial means to complete the procedure. The policy will be brought before council this fall.

U.S.-approved medicinal marijuana study unprecedented

In April, the San Mateo County Health Center in California began studying the feasibility of using self-administered medicinal marijuana as a control for the pain associated with AIDS. Sixty participants are part of a randomized clinical trial to study the use of medicinal marijuana in patients with HIV. The study, which is expected to last a year, will help gather data as to whether medicinal marijuana benefits people with a chronic disease such as HIV-AIDS. The federal government authorized the use of medical-grade marijuana for such a study last November, according to the San Mateo County Health Services Agency. For more information, consult the Health Center's Web site at <www.smhealth.org>.

America's losing the war on drugs

Three-quarters of Americans believe the United States is losing the war on drugs and that the demand for drugs is simply too high to ever eradicate their use, reports the *New York Times*. Released this spring, the poll from the Pew Research Center for the People & the Press also showed that Americans still believe arresting drug dealers and stopping the importation of drugs should be the government's top priority in fighting this problem. A majority of Americans believe that Latin American countries will never be able to control the traffic of illegal narcotics, while 50 per cent believe that more compassion should be shown to people who use drugs. The poll, taken in February of this year, surveyed the views of 1,513 Americans; it has an error margin of plus or minus three percentage points.

British men prone to suicide

Suicide is now the leading cause of death among young British men, according to a *National Post* article. More than 1,700 British men aged 15 to 34 kill themselves each year – a three-fold increase from 1974. Though reasons for this increase are many, changing male role expectations, the transition of England to a service-based economy, female-friendly British teaching methods and men's unwillingness to ask for help – for fear of being labelled a wimp – are often considered to blame. To address this problem, the British government announced the formation this spring of an all-party group on men's health.

Regular use of ecstasy can lead to memory loss

People who regularly use ecstasy for about a year may suffer from short-term memory loss. Researchers at the University of Toronto and the Centre for Addiction and Mental Health observed 15 ecstasy users between the ages of 17 and 31 over a year. They found that their subjects' ability to recall a short passage of prose out loud proved to be increasingly difficult. This finding is the latest piece in a mounting body of evidence detailing that ecstasy is not the harmless, happy party drug its promoters believe it to be. The study was published in the April 10th issue of *Neurology*.

CHRIS HENDRY

One-third of Ontario students report distress

Up to one-third of all Ontario adolescent students report impaired mental health, according to the longest ongoing school survey of adolescents in Canada. In general, the older students get, the more distress they report, say authors of a new report, *Mental Health and Well-Being of Ontario Students*.

However, the flip side is that two-thirds of students do not report elevated psychological distress. About 85 per cent of students state that they feel close to others at school and feel they are a part of their school. Three-quarters say their teachers are first rate, and 94 per cent say they either get along well or okay with their parents. Only one in seven worries about being harmed or threatened at school.

"Despite everything we read or hear in the media, there are still many encouraging findings in this report. A sizeable percentage of

youth have very positive feelings about themselves," says Ed Adlaf, a research scientist at the Centre for Addiction and Mental Health and co-author of the study.

The study, released in May, presents findings from 4,894 Ontario students surveyed in 111 schools in the spring of 1999. It also contains overall trends since 1991, and is a companion piece to the *Ontario Student Drug Use Survey Drug Use Report*.



Its findings reinforce the different ways that female and male students report their problems. Females are more likely to internalize their problems – through depression (reported by three girls to every two boys), low self-esteem, psychological distress and eating disorders – while males tend to externalize their problems. They report higher rates of delinquency, gambling, hazardous drinking and illicit drug use.

Notably, nine per cent of students in 1999 perceived their health as fair or poor, a three per cent increase from 1991.

The study is administered by the Institute for Social Research at York University.

DEBORAH ETSTEN

The full report is available on-line at <www.camh.net/research/population_life_course.html>.

Homeless courts promote rehabilitation, not punishment

In 1999, San Diego County Superior Court Judge David Ryan moved his court of law out of the traditional halls of justice and into Brother Benno's homeless shelter in Riverside.

The idea was to help clear the records of homeless people who had committed non-violent offences by offering nominal fines or suspended sentences in exchange for commitment to rehabilitation programs or community service.

"Homeless court" is an initiative that follows in the footsteps of drug and mental health courts, the sometimes controversial programs aimed at harm reduction and rehabilitation. And it's an idea that's catching on – stateside at least.

Using San Diego as a model, Los Angeles County Superior Court Judge Michael Tynan convened his first court in November 2000.

"The idea is to take folks who might be in treatment for some kind of addiction and are homeless and check them for warrants," says Tynan in a telephone interview.

"Maybe they've got a jaywalking ticket or they've been sleeping on the sidewalk – some people keep warm that way. And you find, if these guys get put through the court system, their treatment disappears. These are fragile

folks and they don't need that kind of abuse."

In his first session, Tynan cleared 20 cases – on charges ranging from loitering to sleeping on the sidewalk to riding transit without paying. He sentenced offenders to time served and says a clear record may help homeless people take one step closer to health and well-being.

The process starts with service providers and shelter workers who check their clients records for minor infractions. The judges bring their courts into the shelters when case-workers assemble a docket full of appropriate clients – people with minor convictions who have shown a commitment to rehabilitation. Tynan convened his second court in February 2001 and Ryan has cleared over 500 cases since 1999.

"I'm happy," says Tynan. "I think these people ought to get recognized for their hard work and they don't. And the people involved all think it's an excellent way to demonstrate that the court is not aloof to the problems of the community."

The closest thing in Toronto, according to Annex Harm Reduction Program Co-ordinator Arthur Manuel, is the Court Diversion Program. This three-year-old program is designed to move minor offenders out of the criminal justice system and toward treatment.

Clients may still need to appear in court. But if, after assessment by a court worker, a person agrees to follow a prescribed program, the Crown withdraws charges – saving the person from a criminal record.

"We get referrals from these courts," says Manuel, who works with clients at Toronto's Seaton House, Canada's largest men's hostel, "and it's about diverting people who need treatment, not punishment."

Critics argue that these courts may force treatment – where people without a psychiatric diagnosis would not be prosecuted for minor crimes such as loitering in the first place. Others are concerned that they act as a Band-Aid solution to the broader problem – the de facto criminalization of mental health patients and the lack of community services.

Supporters like Tynan say these courts save money by keeping minor offenders out of jail, and offer clients a real chance at rehabilitation and healing.

"We want L.A. to become the largest community court in the country and this initiative is a step in the right direction."

CINDY MCGLYNN

An alternative to ECT?

Magnetic therapy holds promise for treating depression

Electroconvulsive therapy (ECT), also known as electro-shock therapy, can be effective in treating severe depression, but has been reported to result in injury and serious side-effects, such as memory loss.

However, a new technique – using similar principals to ECT – has been shown to ease depression in some patients, without the same risk of cognitive impairment, according to Dr. Gary Hasey, head of the ECT program at St. Joseph's Healthcare-Hamilton, Centre for Mountain Health Services. But unlike ECT, it doesn't require anesthesia or involve inducing a seizure for it to work. And it can be administered by only one operator – on an outpatient basis, according to an article in a January issue of the *Canadian Medical Association Journal* (CMAJ).

Referred to as repetitive transcranial magnetic stimulation (rTMS), the technique uses a pulsed magnetic field to alter the electrical activity of the brain.

"It's a much less intrusive, less uncomfortable and much safer treatment [than ECT] as far as we can tell at this point," says Hasey, who is also

clinical director of the Mood-Disorders Program at St. Joseph's Healthcare-Hamilton, Centre for Mountain Health Services and one of the authors of the CMAJ article. "There's no stress on the heart, no stress on the lungs. There are no physical stresses to your bones and muscles. There's no significant cognitive impairment," Hasey asserts.

TMS machines were developed in the 1980s as a diagnostic tool for neurologists. By stimulating the motor part of the brain, they found they could induce movement in body parts to determine if nerve pathways were intact. While early machines could deliver only one pulse every three seconds, contemporary versions can produce up to 50 cycles per second. The technological advancements opened up new possibilities in using rTMS for treatment.

TMS modifies the behaviour of malfunctioning nerve cells using a magnetic field, which is produced by sending electrical current through a copper coil. When the coil is held to the client's scalp, the field passes through the skull and into the brain cortex, inducing small cur-

rents in the brain cells.

"What presumably happens is a change in neurotransmission from this site to other sites," says Dr. Jeff Daskalakis, a Centre for Addiction and Mental Health psychiatrist who specializes in schizophrenia research. Treatment sessions range from 15 or 20 minutes for "short therapy" to 45 minutes for "bilateral treatment" (both sides of the brain). Typically, 10 to 15 daily sessions are needed to produce improvement in mood.

RTMS is still very much at the investigation stage worldwide. In fact, Canada is the only country to permit the sale of TMS machines for treating depression. Even then, the use is restricted to "treatment-resistant" patients who do not respond to antidepressants or other forms of therapy, or for patients who cannot receive ECT for health reasons.

McMaster University in Hamilton has pioneered the technology in Canada, studying rTMS as a treatment tool for more than two years at the Centre for Mountain Health Services. "We probably have a response rate of 30 per cent," Hasey says. "Three out of 10 people who get the treatment get a good result, another one or two might show some improvement, and half would show no improvement."

How long the improvement lasts can vary. For some, it may be a matter of weeks. Others may feel better for months. Hasey tells of one client who has been getting "maintenance treatments" for a year and a half and no longer shows signs of depression. "So it is possible to induce fairly lengthy remissions, but we have not been doing the treatment long enough to say that it's permanent. In fact, the largest body of evidence is that the treatment effect is not permanent."

According to the CMAJ article, results of an open trial indicate that the antidepressant efficacy for TMS and ECT is comparable. But psychotic patients appear to do better with ECT, says Hasey. For those who are able to benefit from rTMS, it appears to offer a gentler, safer option.

And scientists postulate the technology might also be effective for treatment of other mental health problems, such as schizophrenia, as well as neurological diseases such as Parkinson's and Huntington's.

Will it ever replace ECT? "At the moment, it can't be seen as a panacea of any type," Hasey says. "It only works in some people." And he points out that the technology is still quite new." But once more is understood about the optimal way to use TMS, he expects the effectiveness of the treatment to improve.

STEPHEN NICHOLLS

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Young women speak out about depression



Conference participants at an "inner power" workshop

Change

When a group of us sat in a Native healing circle and passed the feather talking stick around, life was given to voices that had never spoken before. Even if you didn't speak and passed the eagle feather on, your presence gave energy to the circle. Sitting in the circle establishes completion. There is no place to hide. No need to hide. Plus, it conjures up memories of childhood and connection.

Makeovers

There is something about changing our physical appearance, if only for one night, that is empowering. We can step into a new energy, a new expression with the swoop of a hair tuck, the heat of a curling iron. I sat on the floor and watched a room full of young women have mini-makeovers. I watched a young girl as she got her hair done, while lip-synching to the song "Survivor." She caught me watching her. She smiled, shy for a second, that she'd been watched. But she didn't miss a word. She sang softly but powerfully to herself. Her mantra: "I'm a survivor."

Inner power

Everyone has inner power. It is a muscle that, like other muscles, needs to be worked out to be strengthened.

Inner power controls the voices in our heads that speak to us. Almost all the women around the circle had negative self-talk about their bodies.

They won't like me.

I'm weird.

I'm fat – I have cellulite.

There is not enough time.

I'm wrong.

VANESSA BEAULIEU

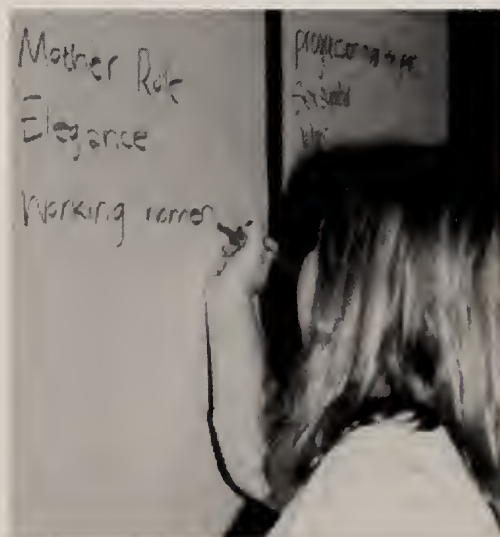
DANAH BEAULIEU

★★★

The following is written by Vanessa Beaulieu, describing the way in which the VALIDITY♀ Conference empowered youth to raise their voices and create something that makes sense in the world.

Voice

Depression was something that everyone had a voice about. ... Some young women were quiet in their expression. Some young women spoke loudly and often. Some young women came ready to use their voices and when they did, they were not heard. It was just not possible for the voices to be taken care of. Sometimes there are no solutions that can fix a wounded voice that is crying out for help.



At the women, minorities and mass media workshop

Research Update

Depressed children more likely to develop adult personality disorders



Illustration: Fred Sebastian

Severe depression in childhood has been linked to a significant increase in the likelihood that an individual will develop a variety of personality disorders as an adult. In upstate New York, researchers followed a random sample of 551 youth aged 16 or younger into their early twenties. They found that the presence of major depressive disorder (MDD) in childhood considerably increased the odds of dependent, antisocial, passive-aggressive and histrionic personality disorders in young adulthood. However, the study failed to confirm an expected link between depression and avoidant personality disorder. Although the incidence of MDD was much higher among female youths, the link between depression and the development of personality disorders did not differ between the sexes. After an episode of depression, youth may have difficulty catching up with their peers in terms of cognitive, emotional and social development, thus increasing the risk that "adult role functioning" will be impaired. Treatment following depression may help children resume normal development, and lessen the risk of their later developing a personality disorder.

Archives of General Psychiatry, March 2001, v. 58: 231-236.
Stephanie Kasen et al, Department of Psychiatry, Columbia University, New York, New York.

Substance use problems higher among adolescents in public care

Substance use disorders (SUDs) are markedly more common among adolescents who receive services from public sectors of care. This is particularly true of juvenile justice, mental health and alcohol and drug sectors, according to a Californian study. Whereas SUD rates among the general adolescent population have been estimated at between six and eight per cent, researchers in San Diego found lifetime SUD rates ranging from 19 per cent among adolescents receiving services from child welfare to 83 per cent among those in the alcohol and drug sector. The researchers assessed 1,036 adolescents between the ages of 13 and 18 using structured diagnostic interviews. Among the sample, 40 per cent had at least one SUD in their lifetime, while 24 per cent had an SUD during the previous year. SUD rates were significantly higher among older youth and boys. The most common SUDs were alcohol and cannabis, followed in order by amphetamines, hallucinogens, cocaine and opiates. Given these high rates of SUDs, the researchers recommend that adolescents in all sectors of care be screened for substance use and assessed for the presence of SUDs.

Journal of the American Academy of Child and Adolescent Psychiatry, April 2001, 40(4): 419-426. Gregory A. Aarons et al, Child and Adolescent Services Research Center, San Diego, California.

Treatment for insomnia may help prevent relapse among alcoholics

Patients being treated for alcoholism frequently report having insomnia, which can significantly increase their chances of relapsing. This suggests that treatment for alcoholism could be improved by simultaneously treating co-occurring insomnia, although that hypothesis has not been tested, according to Dr. Kirk J. Brower and his colleagues at the University of Michigan Alcohol Research Center in Ann Arbor. The researchers studied 172 patients receiving treatment for alcohol dependence, 104 of whom had insomnia. They found that patients with insomnia were twice as likely as those without insomnia to use alcohol to help them sleep. Of the 74 patients reached for follow-up interviews – on average five months after treatment – 60 per cent of those with insomnia had relapsed, compared to 30 per cent of those without insomnia. These results are consistent with other studies, which have found a link between insomnia and relapse. Patients who used alcohol to help them sleep also had higher relapse rates than those who did not self-medicate, but these results narrowly failed to reach significance.

American Journal of Psychiatry, March 2001, v. 158 (3): 399-404. Kirk J. Brower et al, University of Michigan Alcohol Research Center, Ann Arbor, Michigan.

Sexual contact with women reduces likelihood of being diagnosed as a pedophile

Sexual offenders who have had sexual contact with the greatest number of adult women are less likely to be diagnosed as pedophilic, according to Centre for Addiction and Mental Health researchers. However, this only holds true when taking into account not only unconsenting victims, but also the offenders' consenting partners. Among offenders against unrelated children, men with the largest number of child victims were, as expected, the most likely to be diagnosed as pedophiles. Results for offenders against related children were unclear because few had multiple victims. The researchers studied 324 sex offenders, 82 of whom had offended against adult women, 172 against unrelated children and 70 against related children. Phallometric tests measured blood volume in the participants' penises (rather than penile circumference) in response to visual and audio depictions of male and female children, pubescents and adults. By including a group of offenders who were clearly not pedophiles, this test showed a very low likelihood of generating an incorrect diagnosis of pedophilia, while generating positive diagnoses for 61 per cent of those most likely to be pedophiles (those with three or more child victims).

Psychological Assessment, January 2001, v. 13(1): 118-126. Ray Blanchard et al, Centre for Addiction and Mental Health, Toronto, Ontario.

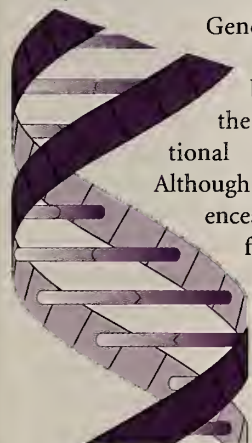
Women smokers more likely to develop bladder cancer

Women smokers have a higher risk of developing bladder cancer than men who smoke at comparable rates, according to a University of Southern California study. The study examined 1,514 individuals (334 women) in the Los Angeles area with bladder cancer, along with 1,514 individually-matched control subjects (334 women). Cigarette smokers of either sex were 2.5 times more likely than nonsmokers to develop bladder cancer, but the risk for women was significantly higher at most levels of smoking. Only cigarette smoking was associated with an increased risk, and not other forms of tobacco use such as cigar or pipe smoking. Filtered cigarettes showed no advantage over nonfiltered cigarettes, nor did light inhalation. The risk increased with the number of cigarettes smoked per day and the number of years smoking, while quitting reduced the risk. Blood samples showed that women smokers had higher levels of 3- and 4-aminobiphenyl (ABP) hemoglobin adducts. ABPs and other arylamines are found in cigarette smoke and are believed to play an important role in the development of smoking-related bladder cancer.

Journal of the National Cancer Institute, April 4, 2001, v. 93(7): 538-545. J. Esteban Castelao et al, University of Southern California, Los Angeles, California.



Twin study offers clues to phobias' origins



Genetic factors appear to play a similar role for both men and women in the development of irrational fears and phobias. Although environmental experiences are the predominant factor in whether someone develops phobias and related irrational fears, genetic factors appear to be mainly responsible for their clustering within families.

Researches arrived at these conclusions after studying 1,198 male-male twin pairs from the Virginia Twin Registry and comparing the results with a previous study of phobias among female-female twins from the same registry. Monozygotic twins were more likely to develop the same phobias studied, but dizygotic twins had similar phobias only for agoraphobia, social and animal phobias. Analysis indicated that twin resemblance for animal, situational and blood/injury phobias is due entirely to genetic factors. Twin resemblance for agoraphobia and social phobia appeared to be the result of both genetic factors and the effect of a common family environment. However, the effect of the common family environment appeared to be significant only among men.

Archives of General Psychiatry, March 2001, v. 58: 257-265. Kenneth S. Kendler et al, Department of Psychiatry, Medical College of Virginia of Virginia Commonwealth University, Richmond, Virginia.

Stigma makes elderly more likely to drop out of depression treatment

Older patients with major depression may be more likely to discontinue depression treatment due to perceived stigma than are their younger counterparts. Researchers in White Plains, New York followed 92 outpatients with major depression over the course of three months. Twenty-nine of the patients were 65 years of age or older; 63 were between the ages of 18 and 64. Although a majority in both groups had negative views of people with mental illness, the younger patients unexpectedly perceived more stigma than did the older patients. Nonetheless, young adults with high scores on the Stigma Coping Scale were 1.3 times less likely to drop out of treatment, while older adults with high stigma scores were 1.7 times more likely to drop out. While we already know that stigma may prevent people from accessing mental health services, this study shows that stigma can affect people's participation once treatment is initiated. Sixty per cent of those who discontinued treatment did so following the first evaluation sessions. It may be that when treatment is prescribed, patients weigh the perceived social costs of mental health treatment against the possible benefits of treatment, and many older adults see the social costs as being too high. The authors conclude that addressing patients' stigma may be useful in improving treatment adherence and reducing the depression.

American Journal of Psychiatry, March 2001, v. 158(3): 479-481. Jo Anne Sirey et al, Weill Medical College of Cornell University, Westchester Division, White Plains, New York.

Errors in prescribing drugs drastically increase overall prescription costs

Incorrect prescribing of drugs likely costs the U.S. economy more than \$177 billion each year, according to a study by Drs. Frank R. Ernst and Amy J. Grizzle of the University of Arizona in Tucson. This is more than double the \$77 billion cost estimated in 1995 by their colleagues Drs. Jeffrey A. Johnson and J. Lyle Bootman of the University of Arizona. Previous research has shown that costs from illness and death caused by prescription drug-related problems exceed the cost of the medications themselves. The researchers analyzed the costs associated with eight drug-related problems. These included prescribing drugs that don't adequately treat a condition; not treating conditions that should be treated; giving too much or too little of a medication; prescribing the wrong drug or not prescribing the needed drug; adverse reactions to the drugs themselves; or interactions with other drugs, food or dietary supplements. Hospital admission accounted for nearly 70 per cent of the costs resulting from drug-related problems. The estimated number of U.S. deaths from prescription drug-related problems rose from 198,000 in 1995 to 218,000 in 2000. The authors recommend that more attention be paid to reducing the preventable costs of these problems.

Journal of the American Pharmaceutical Association, March/April 2001, v. 41 (2): 192-199. Frank R. Ernst and Amy J. Grizzle, College of Pharmacy, University of Arizona, Tucson, Arizona.

MARK DE LA HEY

Avoiding your doctor



The last time Joanna saw a doctor was eight years ago. When asked why she avoids doctors, she replies: "There were so many times in the past that doctors either misdiagnosed or made an original condition worse that I lost trust in them, and frankly became afraid to go."

Like Joanna (not her real name), many people avoid seeing a doctor, usually out of fear. Some fear that their doctor will only confirm what they dread most; for instance, that the pain in their chest indicates an imminent heart attack. Others are afraid of being judged by a medical professional – a situation particularly common among pregnant women who smoke or take drugs. Or like Joanna, some people's past experiences have led them to believe that seeking medical attention worsens their health.

There are a number of health-related fears and phobias that may trigger anxiety, making some people shun medical help. "People with general social anxiety are likely to fear situations where they must deal with an authority figure such as a physician, particularly if the contact involves disclosure," says Neil Rector, head of the Anxiety Disorders Clinic at the Centre for Addiction and Mental Health. There are others, he adds, who may not fear contact with the doctor but who are afraid of the possible diagnosis a doctor might make, and will avoid a medical appointment lest their worst fears be confirmed.

In addition, a fear of needles, of choking during a throat swab, of getting infected from unseen contamination or of seeing blood is enough to keep many people from making an appointment for a yearly physical. More com-

monly, given the prevalence of sexual abuse, many people will avoid situations where they may be touched. Women may not get gynecological exams, for example, equating the use of a speculum with prior sexual violence.

According to Lisa Bernstein, executive director of the New York-based What to Expect Foundation, many barriers also keep low-income women from seeking out prenatal care until late in their pregnancy. At focus groups involving low income women, "many of the women said they were nervous [to seek out medical care] since they were smoking or doing drugs – things they knew were bad for the baby. They were, what I would interpret as, embarrassed to go seek care," says Bernstein. "I have also been told of cases where mothers were afraid that if they tested positive for drug use the baby might be taken from them," she adds. Hence, they avoid seeing any medical practitioner as the imagined consequences are traumatic.

Colette Deveau, manager of family services at the Toronto Native Child and Family Services, also frequently sees pregnant women who don't want any medical attention because they don't want to hear they are making poor choices. "One woman with substance abuse problems told us that she didn't need to see a doctor because she had already had six kids and she knew her body better than any doctor could," recounts Deveau. "In my experience, these statements mask the fact that these women are afraid they will be condemned and worry they may be mandated to seek treatment or risk losing their children."

Health care advertising can also evoke fears about doctors. Dr. Russell Robertson, a family

doctor at the Medical College of Wisconsin, notes that the public is bombarded with undifferentiated information on television that, in some cases, is actually designed to provoke anxiety, so people will seek out medical care. But for some people, it has the opposite effect: it frightens them to the extent that they will avoid going to a doctor, he says.

Fortunately, there are ways of coping with these fears, with the first step being self-appraisal. Robertson has devoted a page of his clinic's Web site to helping people look at what they can do to reduce the terror associated with doctor visits. He suggests they ask themselves a few questions to get at the root of the fear, such as: "Are you afraid of a specific thing, like needles or germs?" and "Do you have a family history of an illness that befalls people in your age group?"

Rector also stresses the importance of helping clients understand their fears. "Once you know what you are facing, you can begin to work on solutions." Many consider the most useful therapy for dealing with fears to be cognitive therapy, where clients identify situations that make them nervous and consciously work to make being in those situations more bearable. After that, they expose themselves to these situations and begin learning that with experience, the fear grows less significant. "Other people may decide that taking a medication is the fastest route to feeling less anxious, but this is not without consequences," says Rector. For one, the medication does not help them learn that their fears might be out of proportion to the event and secondly, they don't learn that they have what it takes to cope.

Joanna says that as she approaches her mid-fifties, she continues to be wary of doctors, though she acknowledges that she may have to see one as she ages. In the meantime, she has been "investigating alternatives," and has found them to be at least as effective as medical intervention.

Joanna's mistrust – and fear – of medical practitioners echo the attitudes of many who seek complementary therapies: people who are dissatisfied with what they perceive as the limitations of Western-based medicine. Unfortunately, some end up opting for complementary therapies "instead of" rather than as an adjunct to Western medicine. So entrenched are their misgivings that they risk not being tested – and consequently treated – for medical problems that could be life-threatening.

LISA SCHMIDT

Dr. Russell Robertson's Web site is at healthlink.mcw.edu/article/936746280.html.

focus on **sexuality**

Sexual side-effects are a turn-off

BY ANGELA PIRISI

THERE IS NOW GROWING AWARENESS OF DEPRESSION AS A real health condition that – like such diseases as cancer, diabetes and heart disease – is highly prevalent in our society. Since 1996, doctor visits for depression have increased by more than a third, and related drug prescriptions have risen 63 per cent, according to Montreal-based health information provider, IMS Health.

And yet the current depression treatment is not without costs. While newer classes of antidepressants tend overall to produce fewer side-effects, sexual dysfunction is still frequently reported by users. Both men and women on the drugs report less sexual desire and a delayed or non-existent orgasm, while some men complain of erectile dysfunction and women of decreased vaginal lubrication.

Among the worst culprits are SSRIs (selective serotonin reuptake inhibitors, such as Paxil and Prozac), which are the most widely used antidepressants today.

Compromising treatment

“Sexual side-effects related to antidepressants affect over 50 per cent of patients with depression and are the number one reason for non-compliance,” suggests Dr. Cindy Meston, assistant professor of clinical psychology at the University of Texas at Austin, who specializes in female sexuality. So besides the obvious frustration and disappointment of a thwarted love life, another great concern is that sexual side-effects may be turning patients off in another manner – making them not want to take their medication.

The first Canadian National Survey on Sexual Dysfunction and Sleep Disturbances, released by the Canadian Mental Health Association in 1997, reported that people taking antidepressants were three times more likely than the general public to report constant sexual problems. According to Dr. Pierre Assalian, director of the Human Sexuality Unit at Montreal General Hospital, the numbers of reported problems have increased as a result of physicians broaching the subject more unabashedly with patients. “Past studies from the seventies showed that only eight per cent of men and women suffered sexual side-effects from antidepressants because it was a standard of practice for doctors not to inquire about details from their patients regarding this issue. When physicians began to ask the question directly, figures soared to 40 to 70 per cent.”

Causing dysfunction

Experts are still guessing as to why various antidepressants inhibit sexual desire and performance. Says Assalian, “We know that dopamine is a sex-friendly neurotransmitter that increases sexual desire. On the contrary, serotonin is a sex-negative neurotransmitter. One theory surrounding depression is that men and women with the condition have low serotonin levels in the brain. The fact that certain antidepressants increase serotonin levels may explain why they adversely affect sexual functioning,” while others, such as Wellbutrin (bupropion), which acts on dopamine, don’t seem to adversely affect sex.

Other theories of pharmacologically-induced sexual dysfunction have to do with impaired blood flow to the genital area and disrupted sexual

responses produced by the parasympathetic nervous system. “Erection, for instance,” says Assalian, “is part of a parasympathetic response to sexual stimuli, but antidepressants nullify or weaken that sexual response.” Meston adds that “only five per cent of serotonin receptors are located in the brain and the other 95 per cent are in the periphery of the body, where they would affect sexual response more directly.”

Countering side-effects

As more evidence builds to show that antidepressants can affect sexual function, the question becomes how best to counteract these side-effects without compromising treatment. Some different approaches include lowering the drug dose; adjunctive pharmacological therapy, such as Viagra, to offset the side-effects; and switching antidepressants. The obvious trouble with lowering medication use is that the depression may not get adequately treated. Combination therapy (e.g., an SSRI plus Wellbutrin) may help to resolve the adverse sexual effects, but Assalian says not enough double-blind, controlled research has been conducted to prove this approach definitively works.

And taking a drug holiday (stopping medication for a few days to facilitate sex) is merely a temporary solution to a long-term problem, Assalian says. And it won’t work for antidepressants with a long half-life; for example, Prozac’s effects can last up to two weeks or more after discontinuing the drug. Abruptly discontinuing an antidepressant, even for a few days, can also produce unpleasant side-effects, such as flu-like symptoms, insomnia and nausea, says Centre for Addiction and Mental Health pharmacist Melissa Yuzda. And there is danger that even temporarily stopping the drug will cause the symptoms of depression to return.

While switching drugs is another option, it is easier said than done. Says Meston, “A trial and error approach to finding the right drug is often a long, drawn out and frustrating process that can make patients want to stop their drug therapy altogether.” As one study from the University of Texas Medical Branch, Galveston, Texas suggests, perhaps the best proven strategy is prevention: treating people with antidepressants “with proven acute and long-term efficacy” that have less frequent sexual side-effects, such as Remeron (mirtazapine), which is not yet on the market in Canada – but available through special access; Wellbutrin or Serzone. Assalian adds that Celexa (citalopram), the newest SSRI, also presents much fewer difficulties.

Of course, unravelling the problem of drug-related sexual side-effects is easily confounded by the fact that depression itself can often be the root cause of sexual dysfunction. So physicians really have to explore any pre-existing sexual problems prior to antidepressant therapy, says Assalian.

Bringing the problem into the light of day and easing patients’ minds about discussing it may prove the largest hurdle of all. “There’s a double responsibility that includes a physician’s willingness to raise the issue of sexual problems, and the patient’s willingness to report problems when they exist,” says Assalian. He suggests that sexuality is still a taboo subject for physicians to address in their practice. “Doctors should really have a poster in their office that says, ‘We speak Sex here.’ I have a Viagra tablet behind my desk, and that usually makes it easier for patients to bring up sex.” ■

Acknowledging clients' sexuality

It's an issue that can no longer be ignored

BY TAMSEN TILLSON

"SEX HAS BEEN OCCURRING BETWEEN CLIENTS [on psychiatric units] since the hospitals were built," says Dr. Paul Fedoroff, former chair of the Clinical Ethics Committee at the Centre for Addiction and Mental Health (CAMH).

And yet for years, clients' sexuality was never acknowledged.

Gradually, however, things are changing. In some hospitals, for instance, checking in to a psychiatric unit may now include a crash course on sex education, contraception and sexually transmitted diseases, along with assessment of clients' competence to consent to future sexual activity. And in future, many of these initiatives will eventually be written into the hospital's official sexual policies.

This is in keeping with the recommendations emanating from a coroner's inquest held in Ontario two years ago. Among these recommendations was a suggestion that the Ministry of Health create a policy "that recognizes a patient's right to sexuality," and design a guideline enabling caregivers to assess a client's capacity to consent to sex. The jury recommended that the policy and guideline be modelled after a policy and manual from British Columbia's Riverview Psychiatric Hospital, one of a very few institutions that already had anything on sexuality on paper.

At Riverview, Dan Eldridge – the hospital's professional practice leader in nursing – notes that it was concerns about HIV-AIDS that first brought the subject to the fore at Riverview in 1995. They were unable to find a sexual behaviours policy at any other psychiatric unit in Canada on which to model their own, however, so they used the closest thing they could find – guidelines surrounding conjugal visits in prisons.

Initially, Riverview's policy on consensual sex required that clients undergo formal sex education before being allowed to use a conjugal house on the hospital's grounds. In practice, however, they found that clients tended to prefer to carry on covertly rather than comply with these cumbersome and somewhat embarrassing requirements. The policy has since been radically revised, notes Eldridge. Clients' ability to consent and awareness of safe sex practices are assessed when they are admitted, rather than staff putting the onus on clients to come to them later.

Other psychiatric hospitals face similar challenges. At the Whitby Mental Health Centre in Ontario, "a conjugal room has been part of the medium security forensic unit since it opened in 1997. But the hospital's policy on use of the private visiting suite applies to visiting spouses, partners and family members," according to administrator Ronald Ballantyne. "The visiting suite has, to date, had limited use."

Fedoroff, who is one of the authors of a Consensual Sexual Behaviours Policy at the CAMH, says he is not aware of any other sexual policy in Canada beside the CAMH's and Riverview's. He says the aim of the CAMH policy is "to raise the standards so that people can have sex in privacy and with dignity instead of having to sneak off to back hallways and engage in the activity more dangerously than they would otherwise."

Sexuality is a basic human right, according to the World Health

Organization. "Two groups that have traditionally been neglected in this," notes Fedoroff, "have been people with mental illness and those with developmental delay." CAMH's policy begins with the understanding that people are capable of sexuality unless proven otherwise, not vice versa.

The problem, notes CAMH bioethicist Dr. Gordon DuVal, is that the caregivers' primary obligations to clients are in potential conflict. "On the one hand, people have a right to sexual expression," he notes, "but on the other side are a number of practical problems. One of these is whether a person has the capacity to consent to sexual involvement."

Mental illness – sometimes coupled with neurological impairment – can interfere with clients' judgment. Some are vulnerable to coercion, while others – such as those with bipolar disorder – may become less sexually inhibited when manic, and less inclined to practise safe sex.

Any policy governing sexual behaviour must take into account clients' potential vulnerability in such situations, while acknowledging that a person can be neurologically impaired or psychotic and still capable of consenting to sex. "It is extraordinarily difficult to find the right balance between freedom and protection from coercion," DuVal notes.

CAMH's Consensual Sexual Behaviours Policy, in effect since the new year, offers a general "guiding framework," without spelling out the "what if" conditions," says Dr. Georgi Beal, chief of nursing practice and professional services, "because there are many, many conditions that may be relevant." The policy is then applied on a per-ward, per-case basis. Basically, the policy states that clients who have been inpatients for more than 15 weeks (at which point the hospital becomes their official residence) have a right to be sexually involved, unless the staff have specific concerns to the contrary. Education on the consequences of their actions – including birth control and STDs – is part of the intervention and condoms are made available. While there are no conjugal rooms, clients will be provided privacy in their own rooms.

On rehabilitation forensic units at CAMH, clients are assessed for their capacity to consent when they arrive and receive health teaching about sex issues, along with everything else they need to know about life on the unit, such as medication, clinical programs, finances and rules.

Sexuality issues "weren't talked about in the past very much," says Shirley Pullan, administrative director of CAMH's Law and Mental Health Program. "The idea of having intimate relations – staff weren't comfortable with it. But the more we talk about it, the less taboo it becomes."

CAMH's sexuality policy is still a work in progress, however, says Fedoroff. Some people are still embarrassed about speaking out about sex. And while there have been complaints that the policy is too vague and sometimes leaves frontline staff wondering what to do, it does open the door for ethical consultations and frank discussions that would otherwise not have taken place, Fedoroff notes. ■

Gay teens feel isolated and alone

And the stress is taking its toll

BY ANDREA GORDON

AS A LEADING LAWYER AND FORMER ATTORNEY GENERAL of Ontario, Ian Scott was known for his sparkling eloquence. But when Scott decided the time had come to disclose his homosexuality to his brother, it took three consecutive nights over dinner together before he could finally find the words, he recalls in his recent memoir *To Make a Difference*.

His brother simply responded, "I know." The year was 1993 and Scott was 59.

Social acceptance of homosexuality has come a long way since Scott's youth, when concealing a gay identity seemed to be the only choice. However, "coming out" is still fraught with peril, says Steven Solomon, a Toronto social worker who counsels gay teens. "[L]eading a double life or a triple life is still typical. And the psychic energy that goes into that can be quite sapping."

For adolescents, who tend to rely heavily on peer and family support, the challenge of facing their own homosexuality can be particularly overwhelming. They may spend years torn between repressing their sexuality, relegating it to a secret life or working up the nerve to come out and risk rejection and discrimination.

Studies indicate that the ensuing stress is taking its toll. "Adolescents whose sexual orientation is not heterosexual are particularly likely to feel alienated and alone," says a 1999 survey of lesbian, gay, bisexual and transgender teens conducted by the McCreary Centre Society of Burnaby, B.C., a youth research and community organization. Those who come out are "at high risk of rejection, isolation and self-doubt" and are three times more likely to attempt suicide than heterosexual teens.

Farzana Doctor of the Centre for Addiction and Mental Health's LesBiGay service, which counsels lesbian, gay and bisexual adults on substance use problems, says the stakes are high for teenagers because most haven't developed the self-confidence or support network that allows them to be who they are. "Generally, younger people are much more dependent upon what their peers and family think of them. They worry that they will be thrown out of the house. The real and perceived risks are higher when you are younger."

For those who are alienated and don't have other gay friends, the feeling of shame and loneliness is compounded. Of the 77 non-heterosexuals surveyed by the McCreary Centre, 46 per cent said they had attempted suicide and 71 per cent said they had seriously considered it. Sadly only half of those who had seen a mental health professional were comfortable enough to disclose their sexual orientation. While the Centre cautions that the survey may not be representative of all homosexual youth, due to the difficulty in finding teens to take part, the findings appear to be consistent with other studies.

Those surveyed also reported using more alcohol than heterosexual teens, and were at least twice as likely to have experimented with marijuana, cocaine and other illegal drugs. This doesn't surprise Alex Dunlop, a counsellor with the Youth Substance Abuse Program offered by the YMCA in Toronto. "When you're met with disapproval or living with something you have to shut down or deny, I think it results in a major existential dilemma of 'who am I.' In adolescence, it's even worse."

Drug and alcohol use also stem from the fact that for years, gay bars, rave and party circuits were the only places where non-heterosexuals could go out, relax and feel part of a community. Intolerable situations at home or at school also drive many gay youth to life on downtown streets, where drugs abound.

The risks exist even among teens who are comfortable being gay, adds Doctor. She cites "internalized homophobia" as the main reason—those hidden negative messages people carry from childhood that can quietly eat away at self-esteem: messages transmitted through casual gay jokes at the dinner table, or even the simple assumption that a successful life means marrying a heterosexual and raising a traditional family.

Margaret Schneider, a psychology professor at Ontario Institute for Studies in Education (OISE) in Toronto, estimates that five per cent of kids in the average classroom will grow up to be gay. And she notes that many more are harmed by homophobia: those with gay siblings or parents, others who may have a same-sex experience in their teenage years, and kids targeted simply because they are incorrectly believed to be gay.

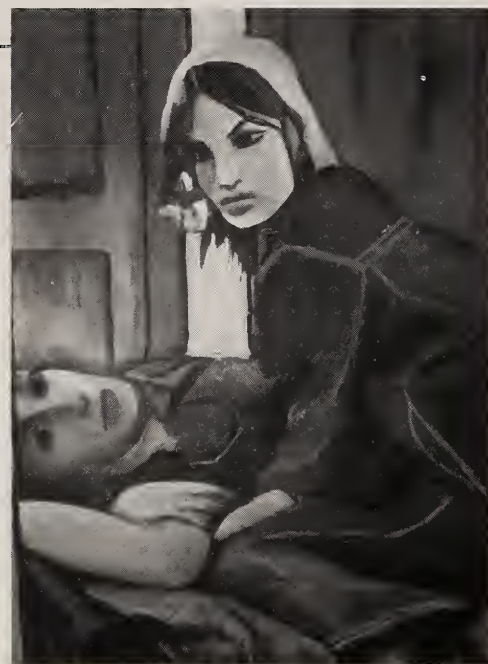
The U.S. Centers for Disease Control and Prevention recently reported that gay students are five times more likely to skip school than heterosexuals and seven times more likely to be threatened or injured with a weapon at school.

The high drop-out rate for gay students was a major incentive behind the Triangle Program, which was set up in Toronto six years ago — both as a way to provide a positive learning environment for gay youth and prepare them to make the transition back to the mainstream system. "For many of them, high school life has been a series of bumps, scrapes, bruises and constant exclusion," says Solomon, who works with the program's gay teens. "Peer identification is the first chip in the wall of isolation."

However, thanks to the Internet, even gay teenagers in remote communities can become part of an on-line community where they can chat and connect with other kids sharing their experience, says Youthquest! general co-ordinator John Trueman.

But to reduce the risks faced by non-heterosexual youth, "support has to be continuous and meaningful and solid," says Solomon. "It's a slow process, but it's starting to unfold." ■

For more information or support, contact: PFLAG (Parents, Families and Friends of Lesbians & Gays), <www.pflag.ca>; CAMH's LesBiGay Service at 1-800-463-6273; Youthquest! at 1-877-944-6293, <www.youthquest.bc.ca>; Lesbian Gay Bi Youth Line at (416) 962-9688; Canadian Gay, Lesbian and Bisexual Resource Directory, <www.gaycanada.com>; and Teens Educating and Confronting Homophobia (TEACH) at (416) 961-0113 ext. 230.



Duo by Kimberly Martin

About Last Night

Beliefs about alcohol predict risky sex

BY IAN KINROSS



I was drinking and there wasn't [a condom] there and it just didn't seem important at the time.

It only happened once. I was intoxicated and stupid.

THESE ARE A COUPLE OF THE observations from a group of 122 young heterosexual men and women in the Toronto club scene – people who recorded the most intimate moments of their dating, drinking and sexual activity in a daily diary, as part of a recent study.

Their words suggest a belief in a simple cause-and-effect relationship

between alcohol use and unsafe sex. But the study's author found more complex factors at play. In fact, some participants' *beliefs* about alcohol seem to be more powerful predictors of unsafe sex than their actual drinking behaviour. "There's still a lot of focus – in health messages, for example – on the *physiological* effects alcohol has in reducing inhibition," says Sandra Bullock, now with the Centre for Social Research on Alcohol and Drug Use at the University of Stockholm in Sweden.

Ironically, she says, the belief in a simple cause-and-effect link between drinking and risky behaviour gives young people an excuse for unsafe sex. The possible consequences: unwanted pregnancy, sterility from diseases like chlamydia, liver failure linked to Hepatitis B or C, and the potentially devastating health consequences of AIDS.

Many studies focus on the obvious correlation between sexual risk-taking and alcohol use, while others paint a more complex picture. For example, researchers Lynne Cooper and Holly Orcutt looked at the link between drinking, condom use and the nature of sexual relationships in face-to-face interviews conducted with 1,417 young adults. They found that drinking and condom use were more common with casual than serious partners and that alcohol became a significant factor only after controlling for partner type. The study, published in the May 2000 issue of the *Journal of Alcohol Studies*, concluded that these links are "complex... and best understood as part of a larger system of interconnected variables."

Bullock titled her study "*About Last Night: Dates, Drinks and Sex* – the first words out of the mouths of some of the young people who had woken up next to a person they may not have known the day before. "About Last Night" can refer to both the good and bad outcomes of dating, Bullock says. Her study recognizes the important role of clubs and other venues, and of alcohol, in how young people meet and become physically and romantically involved. It focuses on young people who are *not* in "committed, monogamous relationships." The participants in her study reported 1,421 dates, 1,173 sexual events and 2,789 drinking episodes in eight weeks. Roughly one-quarter of 326 sexual encounters among casual (first-time) partners were "unsafe": defined as vaginal or anal sex without a condom. "Repeat" or "primary" partners – who knew each other longer – were even more likely to have unsafe sex, even though almost all had concurrent sexual partners.

Alcohol use itself was not a good predictor of unsafe sex in Bullock's study, while perceptions or beliefs were. In fact, in some situations, the use of alcohol was linked to a *reduced* chance of unsafe sex.

Self-handicapping

One of Bullock's key findings concerns a concept she developed called "self-handicapping." Just as a handicap in golf levels the playing field, by acknowledging some players' disadvantage, "using alcohol as an excuse takes the pressure off a young person to even have to try to have safer sex," Bullock asserts. According to her theory, there are four "self-handicapping" beliefs that are powerful predictors of unsafe sex, particularly among "casual" or first-time partners.

These beliefs are that:

- Alcohol reduces inhibition;
- They are less responsible for their actions while under the influence;
- People have or should have safer sex; and
- Unsafe sex is judged harshly by themselves or others.

"If a person was drunk, and was also a self-handicapper, they were almost four times more likely to have unsafe sex than a person who was drunk but was not a self-handicapper," says Bullock. When alcohol was involved but the young people didn't feel its intoxicating effects, self-handicappers were nine times more likely to have unsafe sex than their counterparts who were not self-handicappers. "It appears that the self-handicapping beliefs were more important to the outcome than the drinking itself."

And for those who didn't buy into alcohol's physical effects as an excuse for behaviour, risks were much lower. "Clearly some advance planning seems to be involved," Bullock points out that non-handicappers were more likely to use a condom, but "the stigma attached to carrying around condoms is still so great that even though people expected to have sex, many still did not carry condoms." Young men felt they would appear presumptuous by carrying a condom, while women felt they would appear promiscuous.

Many public health messages have focused on the effects of alcohol in reducing inhibition – and leading to unsafe sex. Bullock doesn't recommend discarding that message, but believes it should be complemented with messages about empowerment and personal responsibility: "We can still think. We can plan. These are the messages and the norms that we should grow up with," in addition to a knowledge about alcohol itself.

"If we give young people an opportunity to pass off responsibility, we're setting them up for problems." ■

Public health recommendations

- Personal responsibility and control need to be emphasized in the context of drinking.
- There is still a low perceived risk of HIV infection, and a high prevalence of unsafe sex in young, sexually active heterosexual adults. A stronger reality check is needed.
- Messages need to address the reality that sex can and does occur outside the bedroom. Carrying condoms needs to become a "normalized" behaviour.

Q
& AWhere sexuality, addiction
and mental health intersect**How do you define healthy sexuality?**

There is no simple definition for this concept. According to one psychiatric textbook, sexuality refers to people's gender identity, sexual orientation, attitudes and feelings, as distinct from "the expression of sexuality and sexual behaviour." However, the way we view healthy sexuality changes over time, and tends to vary by culture, social class, ethnicity and religion. In other words, what is normal is often mired in assumptions of the dominant culture, in terms of what is viewed as "moral," expected or different.

Attitudes toward homosexuality is a prime example of such views. Only this year is China publishing a new psychiatric guide that will remove homosexuality from its list of mental illnesses. And the American Psychiatric Association did not remove homosexuality from its list of mental disorders until 1973. In India, gay sex is still illegal.

When is a sexual or gender issue considered a mental health problem requiring treatment? The DSM-IV classifies disorders related to sexuality as sexual dysfunctions, paraphilias and gender identity disorders.

Sexual dysfunctions refer to a disturbance in sexual arousal and response, causing significant distress and interpersonal difficulties.

Paraphilias are defined as "intense sexually arousing fantasies, sexual urges or behaviours generally involving 1) nonhuman subjects, 2) the suffering or humiliation of oneself or one's partner or 3) children or other nonconsenting persons, that occur over a period of at least six months." Paraphiliac fantasies may be a consistent part of sexual behaviour, or may occur only intermittently (e.g., at times of stress). Regardless, the urges or fantasies create "clinically significant distress" or impair functioning (e.g., at work/school or socially).

A gender identity disorder involves not merely "a desire to be, or the insistence that one is, of the other sex," but also "evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex."

Is there a link between sexual intimacy and substance use problems? Part of healthy sexuality implies a certain comfort level in becoming intimate with a partner. Some people rely on alcohol or other drugs to feel more relaxed and less inhibited in intimate situations. In many cultures, alcohol is viewed as an acceptable – and even expected – part of socializing. Some people never have sex, go to a party or go on a date without drinking.

Historically many gays, lesbians or bisexuals have "come out" through the bar scene, in part "because the bars have been one of the few places where they do not have to deal with homophobic stigma and violence," says Farzana Doctor, manager of the Centre for Addiction and Mental Health's LesBiGay service. Harassment by homophobic co-workers can be one of the many triggers for gay people to use, explains Doctor. Most commonly, this means drinking, followed by marijuana and club drugs.

How do heterosexual assumptions affect people's mental health? While there is slowly growing acceptance of homosexuality, issues of "coming out" and acknowledging a gay identity can still be extremely stressful, particularly for adolescents vulnerable to the potential ostracism of peers and family. The alternative to coming out – keeping their identity a secret – is also fraught with a sense of shame and loneliness. Because not only are gays and lesbians dealing with other people's homophobia; they have often internalized negative beliefs about themselves. Some studies indicate that depression and suicide attempts are higher in adolescent gay populations.

A "heterosexual questionnaire" on the University of Toronto Web site challenges heterosexuals to consider the kinds of questioning that someone who is lesbian, gay, bisexual or transgendered might encounter. Some examples: "Is it possible that your heterosexuality is just a phase you may grow out of?" "Do you think you may have turned to heterosexuality out of fear of rejection?" "Why do you insist on being so obvious, and making a public spectacle of your heterosexuality?"

How does shyness affect sexuality? Shyness and social anxiety interfere with some people's ability to develop a satisfying relationship with an intimate partner. This tends to be more common in men, says Dr. Lynne Henderson, director of the Shyness Clinic in Palo Alto, California.

Shyness can affect all aspects of intimacy: from initially meeting someone, to asking that person out, to expressing a desire to go beyond friendship, and later – performing sexually and being more vulnerable emotionally. Sometimes people's "critical self-preoccupation" prevents them from being empathic and picking up clues from the other person, Henderson says.

At the Social Fitness Center, which Henderson founded, shyness is treated in part by involving clients in role-plays of dating, party situations or other anxiety-provoking scenarios: for example, volunteers are called in so that they can practise having conversations with strangers. And tips are given for ways to engage people in conversation (e.g., to read the newspaper before arriving at a party, so that they will have topics to discuss.)

At the Centre for Addiction and Mental Health's Anxiety Disorders Clinic, clinicians use a cognitive-behavioural approach to address clients' fears of dating, according to the clinic's head, Neil Rector. Rather than viewing clients as lacking social skills, the assumption is that there are several cognitive barriers that inhibit people from feeling comfortable, such as believing that they're boring, or not interesting, or that they have nothing to say, says Rector. By becoming aware of these barriers, clients can then practise new ways of relating.

DIANA BALLON

Sources: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, D.C., R.R. Donnelley & Sons Company; "Homosexuality Not an Illness, Chinese Say," The Associated Press, *The New York Times*, May 8, 2001; Heterosexuality Questionnaire, by Martin Rochlin, PhD, adapted by Mary Gibson and Gwyn Kirk, University of Toronto Web site, <studentservices.sa.utoronto.ca/lgbtqrd/Resources/Homophobia.html>; Kaplan and Sadock's *Comprehensive Textbook of Psychiatry*, 7th ed. Philadelphia: Lippincott Williams and Wilkins, 2000.

Reviews

Reflecting on social and architectural history

THOUGH THE BRICKS AND MORTAR have long since turned to dust, what was once the Provincial Lunatic Asylum at the intersection of Toronto's Queen Street West and Ossington Avenue is resurrected in the pages of *The Provincial Asylum in Toronto: Reflections on Social and Architectural History*. A collection of scholarly essays, the book explores the building of the asylum, how the asylum evolved over a 100-plus years and how, sadly, it was completely demolished just over 25 years ago.

While *The Provincial Asylum* is essentially a historical study, it is also much more. In addition to essays on the design, construction and landscaping of the site, individual contributors outline the prevailing beliefs of mental illness and examine Toronto's architectural past, including the context in which the asylum was built. Also on offer are mini-biographies of those who created the buildings and the medical culture that existed within. Of note are the efforts of the second superintendent, Joseph Workman, who advocated the creation of meaningful activities for patients – efforts that may be considered a forerunner of occupational therapy.

Built 150 years ago, the Asylum was the largest public non-military building in British North America. At that time, it was believed that a combination of rest, medical treatment and access to the outdoors were the necessary ingredients for treating "lunacy." In little time, however, the asylum was overcrowded and con-



Photo by Frank Micklethwaite
Courtesy: City of Toronto and CAMH archives

ditions became deplorable. In one instance, a persistent stench was discovered to be emanating from an enormous cesspool under the main building where, unknown to anyone, three years of human waste accumulated. Once frozen the following winter, it was cut into pieces and hauled to the gardens to thaw.

While most likely intended for readers interested both in the history of buildings and in the treatment of mental illness, the book also may be of interest to anyone who wants to learn more about Toronto itself. Since reading these essays, I have found myself going out of my way to look at buildings still standing from the mid-1800s for clues to how Toronto may have appeared when the Asylum was functional.

Finally, the book is clearly a labour of love for its editor and contributors. The detailed research and depth of analysis collected here demonstrate not only a passion for keeping the asylum's past alive. Its details urge us all to understand where we have come from so we may glimpse where we are going.

LISA SCHMIDT is a writer, editor and graphic artist. She works in communications at the Centre for Addiction and Mental Health.

The Provincial Asylum in Toronto: Reflections on Social and Architectural History. Edna Hudson (ed.). Toronto Regional Architectural Conservancy, Toronto, 2000, pp. 246, \$30.

Issues has both readings offering support, such as *I think I might be lesbian...now what do I do?* to general interest overviews under such headings as **Bisexuals, Heterosexism and Homophobia**.

The **Relationship Issues** section opens up a surprisingly large number of issues including questionnaires in **Quiz on Dating Violence** and **Perhaps You Have an Abuse Problem**, which provide an opportunity to openly and honestly assess your own behaviours in relationships. Both the perspectives of the abuser and that of the abused are presented.

SHEILA LACROIX

Lay My Burden Down

ARGUABLY THE MOST IMPORTANT work of the year, *Lay My Burden Down* helps to put the increase in black suicide into the hearts and consciousness of the reader. Motivated by the death of both their siblings to suicide, Dr. Alvin Poussaint and Amy Alexander have dedicated themselves to exploring suicide in the black community – among its victims, and their survivors.

A haunting look at the past through the eyes of two dedicated warriors, *Lay My Burden Down* is a disturbing critique of America's social reality. The writers highlight the many and varied influences on black suicide: race, class, gender and faith become windows through which to view souls and understand pain. The facts: for African-Americans between the ages of 15 and 24, suicide is now the third leading cause of death behind homicides and accidents. The reality: hopelessness, disillusionment and self-destruction characterize the day-to-day existence of individuals of African descent living with mental illness and addiction in America. Unresponsive and lacking in adequate professional representation from the black community, America's health and social services are criticized for their constant and common assaults on black mental health. And they are held accountable for their continued inaction.

Lay My Burden Down is courageous enough to place blame, but responsible enough to look at solutions – promoting more open dialogue on suicide among the black community, as well as more black professionals represented in psychotherapeutic literature and practice.

It is an ambitious and forceful piece of work, with an agenda to heal and pave the way for what promises to be an ongoing social problem. This spirited work is a must read for every helping professional devoted to critical examination of the past, and a commitment to changing the future.

SHARON MCCLEOD is an addiction therapist at the Centre for Addiction and Mental Health.

Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis Among African-Americans. Alvin F. Poussaint, M.D. and Amy Alexander, Boston: Beacon Press, 2000, 288 pp., \$23 U.S.

Downloaded

A focus on healthy sexuality

The University of Toronto Sexual Education and Counselling (UTSEC) Centre offers an informative, inviting Web site for both the University of Toronto and the broader community at <www.campuslife.utoronto.ca/services/sec/>.

Explore the **Topics on Sexuality and Relationships** to evaluate your own feelings about sexuality, find support or simply learn more about all aspects of sexuality.

The section on **Lesbian, Gay and Bisexual**

A Fragile Revolution pays tribute to a transformation

BY WHAT PECULIAR ALCHEMY DID ex-mental patients transform themselves into consumer/survivors? That is perhaps the central question of Barbara Everett's new book, *A Fragile Revolution: Consumers and Psychiatric Survivors Confront the Power of the Mental Health System*.

Based on interviews with 19 members from the Ontario consumer/survivor movement in 1994-5, Everett also explores the process of partnership with the government of the day, and the transformation of personal pain into political activism.

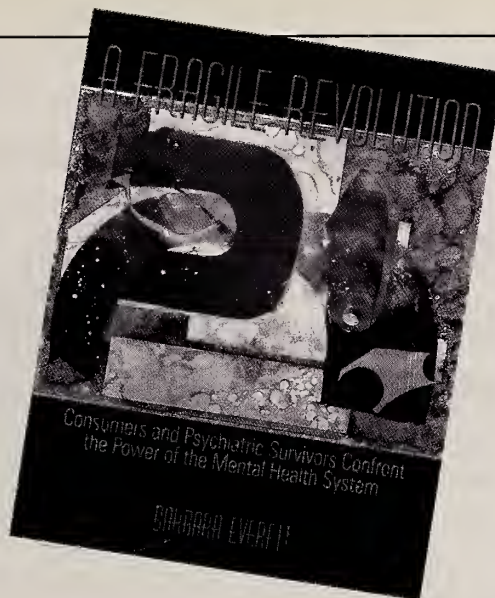
This is not the first time these issues have been addressed through academic analysis, nor will it be the last. Dr. Katherine Church did her PhD thesis on the impact of the survivor movement on social policy and on herself. While Everett's book is less intensely personal, it still manages to recreate the voices and the atmosphere of expectation and optimism that surrounded us in the mid-1990s.

Everett is a professional. She has worked in institutional and agency settings and has a valid take on the nature of power and powerlessness, control and being controlled. For psychiatric survivors, her description of the interactions between staff members from different disciplines on wards, and how that affects the nature of the care offered, as well as the climate of fear most work in, will be instructive. And confirming.

She quotes the late Marilyn Nearing: "We had a week-long workshop with consumers and mental health professionals in attendance and I heard them saying the very same things as us. 'I'm not in control. There's no money... no support.' There were front-line staff who clearly didn't know what their agency budgets were. They weren't taking personal responsibility, just like consumers didn't take responsibility over their own medications and their own therapy... The same sounds of hopelessness. The same sounds of dependency. It rather frightened me because if the staff aren't empowered, how can they pass the power along to their clients?"

Quotations from consumer/survivors make the book come alive, and accurately evoke that sense of time and place that for many of us has receded into history, a not fully examined or understood history. The movement today still has no time for reflecting on where we've come from, how far we've travelled, and how much further we have to go.

Even the label of "ex-mental patient," once used so often, and often so pejoratively, now



sounds so archaic, so limiting and inadequate. As Everett rightly claims, we are in the face of a movement whose participants, "despite their difficulties, lead full and useful lives and who, as a part of their activism, lecture at universities, speak at legislative hearings, sit on powerful committees, lead rallies, make films, set legal precedent and on and on -- achievements of which most of us only dream."

How was all this human potential and ability hidden from the caregivers, the social workers, psychiatrists and psychologists and from the "mentally ill" themselves?

It is a remarkable transformation, in a stunningly short period of time -- though for some of us it feels like eternity -- and one that is mirrored now in many countries, many lives.

Everett has done a good service to professionals and clients alike through this work. Though there is the necessary jargon of the discipline, it doesn't overwhelm her writing; *A Fragile Revolution* is an accessible and readable book.

There is a particular poignancy, even yearning, in her summation, and I'll let her tell it in her own words:

"Prevailing wisdom... identifies a diagnosis of mental illness as a life-long burden, sentencing sufferers to the bleakest of futures characterized only by decline. The respondents in this study each received such a sentence...yet they stand as living proof that things do change and people can get better. From the perspective of this work, exactly by what process this miracle occurs remains a mystery."

PAT CAPPONI is a Toronto author and psychiatric survivor. Her fifth book, which is on hospitalizations, will be published by Penguin in 2002.

A Fragile Revolution: Consumers and Psychiatric Survivors Confront the Power of the Mental Health System. Barbara Everett. Waterloo: Wilfrid Laurier University Press, 2000, 251 pages, \$32.95

Nicotine and Public Health explores tobacco alternatives

NICOTINE AND PUBLIC HEALTH IS A timely book that examines the growing use of alternative nicotine delivery systems -- such as nicotine gum, the patch, nicotine inhalers, lozenges and "smokeless" cigarettes -- as alternatives to traditional smoked, chewed and snorted tobacco. And it addresses the impact of these alternatives on public health.

The book is based on a workshop and policy panel made up of nicotine and tobacco, public health and health policy experts. The authors of each chapter include many of the world's leaders in tobacco and nicotine research, but the focus is North American -- a practical necessity because of international variability in regulations and policies.

Alternative nicotine delivery systems were mainly introduced as aids to smoking cessation, and to ease withdrawal from nicotine dependence. The difficulty of achieving long-term abstinence from tobacco, and the potential to avoid some of the harms of smoked tobacco, have led to the possibility of long-term maintenance use of nicotine via these alternatives. The book places the products in the historical context of tobacco use, and compares the effects of nicotine with those of tobacco. While nicotine is not harmless, its use avoids the toxic -- and sometimes cancer-causing effects -- of tobacco smoke. The potential benefits of nicotine maintenance are weighed against its disadvantages: continued drug use rather than abstinence and the possibility of people who have never smoked, especially youth, using nicotine.

The authors consider the public health and policy implications of nicotine's entry into the marketplace, including comparisons with the experience of methadone maintenance and discussion of harm reduction approaches. The book concludes with agendas for research, regulation and monitoring of the products, and policy recommendations from a core panel of participants. *Nicotine and Public Health* is a valuable current and historical reference, as well as a jumping-off point for future directions.

JOAN BREWSTER is a research consultant studying the health of health professionals and their roles in tobacco control and addictive behaviour. She is also an assistant professor in the Department of Public Health Sciences at the University of Toronto.

Nicotine and Public Health. Ferrence, Roberta, Slade, John, Room, Robin, Pope, Marilyn. (Eds). Washington D.C.: American Public Health Association, 2000, \$47 US.

The Last Word

Sexually speaking

How to open up public discussion of HIV/AIDS in India without invoking political gunfire

BY LORI MCDUGALL

IN A COUNTRY LIKE INDIA, WITH A POPULATION OF ONE BILLION, you would think that sex is a pretty popular subject. Yet for many Indians, sensuality belongs to literature, art and the cinema hall – not to real life.

Young women may swoon over the latest Bombay film-industry stud, but will refuse to travel alone in a rickshaw across town for fear of being branded as a “loose” woman. Young men, meanwhile, continue to vent their premarital frustrations through “Eve-teasing” – the local term for sexual harassment. Sex education is still a thorny subject for Indian teachers, and gay sex is still illegal.

No one is really sure how middle-class India has become so terribly uptight about sex. But the lack of public education and open discussion, both within and outside the family, has dangerous consequences in the era of HIV-AIDS. By the most conservative estimates, India is home to 3.8 million people with HIV-AIDS – more than the population of Montreal and Halifax combined. And nearly one per cent of those between the ages of 15 and 49 are HIV positive.

To redress this growing epidemic, the government of India has asked BBC World Service Trust, a non-profit charitable trust operating within the BBC, to develop a major public awareness campaign in north India on HIV-AIDS. So imagine our challenge – to open up important new areas for public discussion about HIV transmission, protection and support for people living with AIDS – without invoking political gunfire?

Our campaign will focus on safe sex messages, as 70 to 75 per cent of people with HIV in India have contracted the virus through sexual transmission. However, secondary messages will refer to alcoholism and drug addiction, since unprotected, multi-partner sex is often linked to alcohol abuse.

Over the past 10 years, a number of HIV-prevention initiatives have been implemented in south India, where HIV infection first took root in the country, spread by unprotected sex in red-light areas and between truck drivers and commercial sex workers along the highways between these cities. Happily, these states are now seeing a rise in condom sales and a decrease in multi-partner sex. This has been achieved through a mix of peer-counselling schemes among adolescents, truck drivers and commercial sex workers, condom promotion at gas stations and roadside eateries, and effective mass-media campaigns that use humour and drama to persuade audiences to practise responsible sexual behaviour.

North India, however, presents a different set of challenges for effective HIV-AIDS campaigning. Here, poverty and cultural conservatism are at their zenith in India. HIV infection remains low, at 0.25 per cent of the general population, but rates are rising steadily. Last summer, India's national security act was invoked to settle a major incident here involving a small health-education charity that published a pamphlet



Editorials do not necessarily reflect the views of the CAMH. We welcome submissions from our readers. For information, contact: The Editor
The Journal of Addiction and Mental Health
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Ontario M5S 2S1
tel (416) 595-6714
e-mail <journal@camh.net>

documenting purported cases of incest, anal sex and the link to rising HIV infection rates in the area. The leaders of the non-governmental organization (NGO) were handcuffed and paraded to jail as crowds jeered. Even progressive national newspapers carried thundering editorials about the “shame” that the charity had reaped upon the good name of the people of north India. Though some doubts have been raised about the accuracy of the research and the credibility of this particular NGO, it is sobering to see how easily one can go astray in raising public awareness on politically sensitive issues like sexual behaviour.

We expect to rely on TV to reach a vast segment of the population. TV audiences are mushrooming, far outstripping the growth rate of radio. Today, India has more than 500 million TV viewers – twice that of 10 years ago. A large chunk of these viewers are students and adolescents, who form the key audience for HIV-AIDS education. The potential for public education is vast.

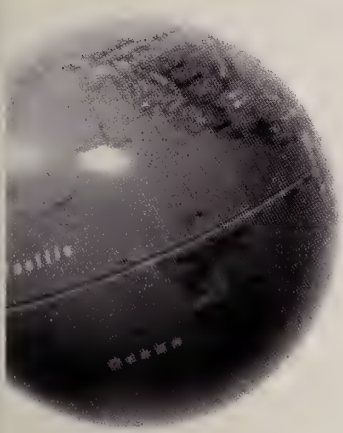
And India loves its family-based TV dramas, with all the melodrama and masala that can be packed in. So one idea may be to produce a short-drama series called “Dilemmas,” with each episode echoing the theme of responsible sexual behaviour. For example, in one series, a woman may discover that her husband has been having an affair. What should she do? Confront him? Demand that he stop seeing the other woman? Insist that he get an HIV test? The TV audience is invited to participate by the series narrator, who will ask them to vote by phone, letter or fax, with their votes determining the resolution of the episode, which would be aired the following week.

The real purpose of the dilemma, of course, is to get viewers to talk to each other in their own living rooms, to ask each other, What would *you* do in that situation? By using drama to open up the issues, we hope that parents and teenagers, and even husbands and wives, will start to talk about issues that they never dared discuss before. In doing so, we hope to pique their curiosity for more information, which could be given through TV commercials starring some of the “Dilemma” actors or via a youth-oriented call-in radio show: callers could seek advice about their relationship problems, health concerns and even HIV-AIDS questions, while others could listen in to the situations discussed, even if they're too shy to pick up the phone themselves.

Yes, the task is daunting and the risks are high. But the potential for widespread social change is even bigger. TV is a largely untapped tool for HIV education in many developing countries. We hope that this project will go some distance toward changing that. ■

Lori McDougall is the project manager of BBC World Service Trust in New Delhi.

Conferences



CANADA

42nd Annual Institute on Addiction Studies

July 8–12, Barrie, Ontario.
Contact: Alcohol and Drug Concerns Inc., 112-4500 Sheppard Ave. E., Toronto, ON M1S 3R6,
tel (416) 293-3400, fax (416) 293-1142,
e-mail <info@concerns.ca>,
web <www.concerns.ca>.

Better Recognition and Treatment for PTSD, GAD, Trauma, Dissociation and Other Social Psychiatric Disorders

July 12–15, Vancouver, British Columbia.
Contact: CME, Inc., 2801 McGaw Avenue, Irvine, CA 92614 USA,
tel 1-800-933-2632 / (949) 250-1008,
fax (949) 250-0445,
e-mail <infostore@cmeinc.com>.

International Association of Gerontology: 17th World Congress

July 16, Vancouver, British Columbia.
Contact: Dr. Gloria Gutman, Director, Gerontology Research Centre, 515 West Hastings St., Vancouver, B.C. V6B 5K3,
tel (604) 291-5062, fax (604) 291-5066.

World Federation for Mental Health Congress

July 22–27, Vancouver, British Columbia.
Contact: The World Assembly for Mental Health 2001, c/o Venue West Conference Services, 645-375 Water St., Vancouver, B.C. V6B 5C6,
tel (604) 681-5226, fax (604) 681-2503,
e-mail <wamh2001@venuewest.com>.

International Society of Psychoneuroendocrinology

August 4–8, Quebec City, Quebec.
Contact: Nicholas Barden,
tel (418) 654-2152, fax (418) 654-2753,
e-mail <ISPNE2001@crchul.ulaval.ca>.

ACT prACTice:

Putting the Pieces Together

September 27–28, Ottawa, Ontario.
Contact: P.G. Mitchell & Associates Inc., 174 Oakridge Blvd., Nepean, ON K2G 2V2,
tel (613) 225-1435, fax (613) 225-0130,
e-mail <pgrimitch@cyberus.ca>.

International Symposium on Mental and Behavioral Dysfunction in Movement Disorders

October 10–13, Montreal, Quebec.
Contact: Marc-André Bédard, Chair of the Organizing Committee, The Movement Disorder Society, Coplanor Congrès Inc., 511 Place d'Armes, #600, Montreal, QC H2Y 2W7,
e-mail <dsorders@coplanor.qc.ca>,
web <www.movdis2001.org>.

Generation to Generation: Breaking the Intergenerational Cycle of Trauma

October 15–16, Toronto, Ontario.
Contact: Kristen Cox, tel (416) 972-1935 ext. 3345, fax (416) 924-9808,
e-mail <training@hincksdellcrest.org>.

Canadian Society of Addiction Medicine

"Mind, Body and Spirit: Getting It All Together"

Oct 18–21, Calgary, Alberta.
Contact: Joan Sweeney, CME Office, 3330 Hospital Drive NW, AB T2N 4N1,
tel (403) 220-8458, fax (403) 270-2330,
e-mail <sweeney@ucalgary.ca>,
web <www.csam.org/annual/CSAM.pdf>.

Ontario Conference on Mental Health and Addiction:

"Reclaiming our Roots"

October 22–23, Toronto, Ontario.
Contact: Allen Flaming,
tel (416) 977-5580 ext. 4121,
fax (416) 977-2264,
e-mail <aflaming@ontario.cmha.ca>,
web <www.ontario.cmha.ca/conf2001/index.htm>.

Depression Across the Life Span

October 29–30, Toronto, Ontario.
Contact: Kristen Cox, tel (416) 972-1935 ext. 3345, fax (416) 924-9808,
e-mail <training@hincksdellcrest.org>.

Treating Affect Phobias in Short Term Dynamic Psychotherapy

November 15–16, Toronto, Ontario.
Contact: Kristen Cox, tel (416) 972-1935 ext. 3345, fax (416) 924-9808,
e-mail <training@hincksdellcrest.org>.

51st Annual Meeting of the Canadian Psychiatric Association

November 15–19, Montreal, Quebec.
Contact: Lyne Gagnon, CPA Head Office, 260-441 Maclaren Street, Ottawa, ON K2P 2H3,
tel (613) 234-2815 ext. 231,
fax (613) 234-9857,
e-mail <lgagnon@cpa-apc.org>.

UNITED STATES

Alternatives 2001

August 23–26, Philadelphia, Pennsylvania.
Contact: National Mental Health Consumers' Self-Help Clearinghouse, 1211 Chestnut St, Suite 1207, Philadelphia, PA 19107,
web <www.mhselfhelp.org>.

109th Convention of the American Psychological Association

August 24–28, San Francisco, California.
Contact: American Psychological Association Conventions Office, 750 First Street, NE, Washington, DC 20002,
tel (202) 336-5500 ext. 6020,
web <www.apa.org/convention>.

Enhancing Outcomes in Women's Health

October 4–6, Washington, D.C.
Contact: Wesley Baker,
tel (202) 336-6120, fax (202) 312-6490,
e-mail <wbaker@apa.org>.

Cont'd...



UNTIL NOW, JOHN HAD NEVER
TAKEN SERIOUSLY A CONNECTION
BETWEEN GAMBLING AND DRUGS.

Institute on Psychiatric Services

October 10–14, Orlando, Florida
Contact: APA Office of International Affairs, 1400 K Street NW, Washington, DC 20005,
tel (202) 682-6000,
fax (202) 682-6850,
e-mail <apa@psych.org>.

Reaching Underserved Trauma Survivors Through Community-Based Programs

December 6–9, New Orleans, Louisiana.
Contact: International Society for Traumatic Stress Studies, 60 Revere Dr., Suite 500, Northbrook, IL 60062 USA
tel (847) 480-9028, fax (847) 480-9282,
e-mail <conf@istss.org>,
web <www.istss.org>.

American Psychiatric Association Annual Meeting

May 18–23, 2002, Philadelphia, Pennsylvania.
Information: APA Office of International Affairs, 1400 K Street NW, Washington, DC 20005,
tel (202) 682-6000, fax (202) 682-6850,
e-mail <apa@psych.org>.

ABROAD

2001 Conference of the Stress and Anxiety Research Society

July 12–14, Majorca, Spain.
Contact: Javier Pérez Pareja,
tel 34 971 173 038 / 34 971 172 556,
fax 34 971 173 190,
e-mail <dpsjpp0@ps.uib.es>.

3rd World Congress for Psychotherapy

July 14–18, Vienna, Austria.
Contact: World Council for Psychotherapy,
tel 43 1 512 0444, fax 43 1 512 0570.

International Congress for Psychotherapy in China – Kunming Psychotherapy: Dialogues between East and West

August 20–24, Kunming, China.
Contact: Congress Bureau,
KunmingKongress 2001,
Prof. Ille Oelhaf, Agathenstr.3, 20357,
Hamburg, Germany,
tel 04 041 355 196, fax 04 041 355 196,
e-mail <KunmingCongress@aol.com>.

10th European Conference on Developmental Psychology

August 22–26, Uppsala, Sweden.
Contact: Uppsala Kongress & Konferens AB ECDP, Dragarbrunnsgatan 35, SE-753 20 Uppsala, Sweden,
tel 46 18 15 0060, fax 46 18 13 4050,
e-mail <Kongress@ukkab.se>.

First International Conference on Reducing Stigma and Discrimination Because of Schizophrenia

September 2–5, Leipzig, Germany.
Contact: University of Leipzig, Department of Psychiatry, Johannisallee 20, 04317 Leipzig, Germany,
tel 49 341 97 24 535,
fax 49 341 97 24 539,
e-mail <stigma2001@medizin.uni-leipzig.de>,
web <www.together-against-stigma.de>

44th International Conference on the Prevention and Treatment of Dependencies

September 2–6, Heidelberg, Germany.
Contact: International Council on Alcohol and Addictions,
web <www.icaa.ch>.

12th South African Association of Child and Adolescent Psychiatrists and Allied Professions National Congress

September 5–7, Braamfontein, South Africa.
Contact: Melody Maddocks,
tel 011 717 2033,
fax 011 484 9676, e-mail
<melody_maddocks@witshealth.co.za>.

International Psychogeriatric Association's 10th International Congress

September 9–14, Nice, France.
Contact IPA Secretariat,
tel 847 784 1701,
fax 847 784 1705,
e-mail <ipa@ipa-online.org>,
web <www.ipa-online.org>.

XXXI Annual Congress of The European Association for Behavioural and Cognitive Therapies (EABCT)

September 11–15, Istanbul, Turkey.
Contact: EABCT 2001 01 31,
tel/fax 90 312 428 5018,
e-mail <kognitif@hotmail.com>.

Conference of the International Society of Addiction Medicine (ISAM)

September 12–14, Trieste, Italy.
Contact: Cristiana Fiandra,
tel 040 368343, fax 040 368808,
e-mail <isam@theoffice.it>.

3rd International Scientific Conference

Serial Murders and Social Aggression: Expectations for the 21st Century
September 18–21, Rostov-on-don, Russia.
Contact: Olga A. Bukhanovskaya,
tel 7 863 2 67 4815, fax 7 863 2 53 0611,
e-mail <bux@jeo.ru>.

Psychopharmacology 2001

September 20–22, Cape Town, South Africa.
Contact: Sune van Rooyen,
tel 27 21 938 9245, fax 27 21 933 2649,
e-mail <sdk1@gerga.sun.ac.za>.

International Federation of Psychiatric Epidemiology Asia Pacific Regional Conference Mental Health: Epidemiology and Service Needs

September 26–29, Shah Alam, Malaysia.
Contact: Saroja Krishnaswamy,
tel 6037 958 4788 / 970 2665,
fax 60 379 588 322,
e-mail <kkz@tm.net.my>.

World Psychiatric Association European Congress

September 30–October 3, Madrid, Spain.
Contact: Tlesa OPC, S.L.,
tel 34 91 361 26 00, fax 34 91 355 92 08,
e-mail
<wpa_eurocongress@tlesa.es>,
web <www.tlesa.es/eurocong>.

XVII World Congress of Social Psychiatry

"Science, Psychiatry and Society – Search for Synergy"
October 27–31, Agra, India.

Contact: Institute of Human Behaviour and Allied Sciences, PO Box 9520, Delhi, India 110095,
tel 91 11 2114025/2112136,
fax 91 11 2299227,
e-mail: <wasp_congress@vsnl.com>,
web <www.17thwaspcongress.com>.

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Number 1

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**Cultural issues
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Cover



Untitled, Pascale Reboul, Watercolour, 12" x 16"

Pascale Reboul is a self-taught poet, writer and visual artist. She has published two books of poetry in France and is host of "Wild Mind," a poetry reading series held through the Centre of Addiction and Mental Health's (CAMH) Workman Theatre Project. Her art has been shown at various Toronto area exhibits. The cover art is on display at CAMH's Queen Street site.



News from the Centre

One of the Centre's core activities is research. The driving force behind it is to gain a better understanding of mental illness and addiction. Ultimately, we hope that increased understanding will lead to better treatments and prevention strategies that will improve the quality of life of the people we serve.

The Centre engages in many research activities. Our neuroscience community strives to further our understanding of pharmacology and the neurobiological roots of addiction and mental illness. The clinical research area develops new psychotherapies and evaluates new treatments, as well as improving our understanding of the psychological factors underlying addiction and mental illness. The Centre's community- and policy-based research focuses on social factors, policy formation, prevention and the efficacy and impact of new initiatives. Our researchers take great pride in developing world-class initiatives and seeking the means for quality clinical "bedside" care.

As the Centre continues to move forward, we will establish a more prominent role for research in our educational programs and increase links with other health care initiatives, thereby improving our ability to translate research into practice and further extending the impact of our research across Canada and the world.

The most recent Research Annual Report that highlights CAMH's research initiatives over the last year is now available. To order a copy, call (416) 979-4250 or visit our Web site at www.camh.net/research.

On another note, the CAMH Foundation will host the 8th Annual Courage to Come Back Awards in May. The success of these awards depends on nominations from people and agencies across the province. Please nominate the most courageous person you know. The deadline is February 15, 2002. For a nomination form, call (416) 979-6909 or visit our Web site.

CHRISTA HAANSTRA

Correction

In the November/December issue, the phone number given for Gillian Woolner in News from the Centre was incorrect. The correct number is (705) 730-6569. The *Journal* regrets any confusion this may have caused.

Note from the Editor

Most of us have used some form of self-help or community support to deal with problems that we face from time to time in our lives – illness, divorce, the death of a loved one, emotional upsets or strains. Talking over these problems with friends or other people who have lived through them can help us to cope with today's difficulties and learn to deal with tomorrow's challenges.

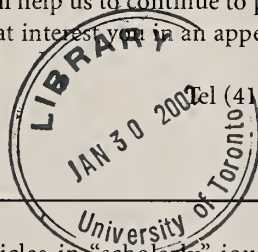
The widespread use and diversity of self-help support groups has steadily increased over the past 20 years. In fact, a group exists for every health condition identified by the World Health Organization. Such groups are becoming a viable part of the health care system, reducing social isolation through important non-tangibles of caring and the wisdom that comes from struggling with problems in concrete, shared ways. Community support, too, finds its strength in empathy, the exchange of ideas and the feeling of hope shared by group members.

The stories in our focus section show how self-help and community support groups link together the wide spectrum of people, mental health and addiction issues and viewpoints. As Tamsen Tillson's story reveals, community support groups for sex offenders may provide the help these ostracized individuals need to successfully reintegrate into the community. Vicki O'Brien describes how ethnoracial self-help groups address cultural issues that may act as barriers to accessing effective mental health services. The barriers erected by social isolation are being further eroded by the growth of on-line self-help groups, as Nate Hendley's story shows. With the accessibility and anonymity offered by the on-line medium, more people with mental health or addiction issues are reaching out for support.

As the new editor of the *Journal*, I urge you to complete the readership survey that you will find in this issue. We would like to make some changes to the *Journal*, and your input will guide us in the process. In the spirit of mutual support, I ask you to share your ideas; your feedback will help us to continue to provide you with the stories and information that interest you in an appealing format.

HEMA ZBOGAR

Tel (416) 595-6714 e-mail hema_zbogor@camh.net



letters

I admire much about your journal. However, I was taken aback by the issue containing the piece I was asked to write about drug companies, Sarafem and alleged premenstrual mental illness. In the Note from the Editor, the previous editor, who had solicited my work, said about my piece only that it "presents one side of the argument and will be balanced by another perspective in a future issue." The implication that my piece is unbalanced is seriously damaging to the reputation of a writer who has carefully evaluated the relevant research, co-authored a major research methodology textbook and long been considered an expert on women's mental health. The editor's word choice was entirely different from what she had repeatedly described as her own position.

In that issue, you also printed totally uncritically an article by an unnamed author advocating giving Luvox to children – and for shyness! How can a journal connected with drug addiction treatment do this? When I expressed concern, the editor replied that that article was taken from a journal. But rare these days is the person who is unaware that

articles in "scholarly" journals can be profoundly flawed, a danger perhaps intensified for drug studies, which are often funded by pharmaceutical corporations.

Hopefully, you will reconsider your policies.

Paula J. Caplan, Ph.D., Brown University

Response from the editor

Our mandate at the *Journal of Addiction and Mental Health* is to provide our readers with a variety of perspectives on the issues we explore. Our intent in the Note from the Editor was to highlight for our readers that we strive to present various opinions, and that readers could anticipate another equally valid perspective on the topic in a future issue. We apologize for any misunderstanding the Note from the Editor may have caused and plan to revisit our policy regarding how we announce upcoming publication of different perspectives.

In Brief

Drug sales up to cope with terrorist attacks

Sales of anti-anxiety drugs, antidepressants and sleep aids have increased throughout the United States and particularly in New York City since the events of September 11, according to NDC Health in Atlanta, Georgia. Prescription rates for anti-anxiety drugs alone until the week ending September 28 increased by 8.6 per cent nationally and 25 per cent in New York City compared to the week before the events. The trend is expected to continue as a result of psychiatric outreach to help people cope and the expectation that people will worry about future attacks.

ECT forbidden in Slovenia

Lobbying by patients' rights groups has led to the abolition of electroconvulsive therapy (ECT) in Slovenia, a small country nestled among Italy, Austria, Croatia and Hungary. According to Igor Spreizer, co-chair of ALTRA, the Committee for Innovation in Mental Health, the only exception to the ban is a small number of clients who are referred to nearby Zagreb, Croatia, where ECT remains in use. Slovenian authorities claim that only between three and twelve clients are referred each year.

More drinking, fewer dining



U.S. wine sales have increased since the attacks of September 11, but restaurant consumption has decreased, according to market research firm ACNielson Adams Partners. Before that date, wine sales in retail stores had increased between 2.5 and four per cent weekly compared to one year earlier. After September 11, wine sales increased 6.2 per cent during the week ending September 15 and eight per cent during the week ending September 22. While alcohol sales are known to increase during periods of economic hardship, the decrease in dining out may hurt smaller wineries that sell primarily through restaurants.

Depression, obesity, children and television



Photo Credit: ARAPO and CAMH

Children of obese and depressed mothers watch television at least half an hour more a day than other children, according to a study of 150 low-income women presented at a Quebec conference of the North American Association for the Study of Obesity in October. Children of mothers who are obese watch television about 2 1/2 hours a day, and children of mothers with depression watch three hours a day. The average child was found to watch two hours a day. As excessive television watching is a culprit in childhood obesity, the findings suggest that considering mothers' health and getting them to turn off the television will improve their children's health.

Dutch may allow pharmacies to sell marijuana

In October, the Dutch Cabinet passed a motion that could enable pharmacies to fill prescriptions for marijuana, reports the Associated Press. If the measure passes a vote in Parliament – still anticipated at the time of this writing – Dutch pharmacies could dispense pharmaceutical-grade marijuana that had been tested by a government agency. The bill also contains a provision that would have the government pay for properly prescribed marijuana. Currently, marijuana is illegal, but the sale of small amounts in coffee shops is permitted.

Russia calls for war on drugs

Russian President Vladimir Putin called for all “judicial, administrative and educational”

methods to be used to combat drug use and importation into Russia, reports the weekly health review *Import*. In a September address to the Security Council that was broadcast throughout Russia, Putin likened the narcotics industry to international terrorism and vowed to “close all channels of distribution for narcotics, both externally and internally.” Putin also called for an increase in the number of drug rehabilitation centres, especially for impoverished people with addictions.

Sleep patterns predict adolescent depression

Adolescents with reduced REM (rapid eye movement) sleep and intense eye movements during REM sleep may be at risk for depression or its recurrence. The finding is a result of an investigation into the longitudinal clinical course of depression and its predictors in adolescents undertaken by researchers at UCLA. Twenty per cent of adolescents in the study exhibiting this sleep pattern developed depression. As depression is undertreated in adolescents, and children with depression often have difficulty adjusting to adult life, this finding may make it easier for doctors to screen for and begin treating depression.

Portuguese farmers protest new drunk-driving law

Portuguese farmers are protesting a new drunk-driving law they say will cripple the country's wine industry, reports Reuters. The new standards that went into effect on October 1 lower the acceptable blood alcohol level to 0.2 grams per litre from 0.5 grams. Wine sales have dropped between 30 and 40 per cent since the law came into effect. Although Portugal has the highest rate of fatal road accidents in Europe, the Portuguese Farmers' Confederation contends these accidents are caused by the poor state of Portugal's roads, not by drunk drivers. **CHRIS HENDRY**



Program mends relationships torn by elder abuse

SHEILA HAD ALWAYS SEEN A BRIGHT FUTURE for her son Jim and, in her eyes, he had lived it – until Jim lost both his marriage and his job. At age 48, Jim moved back to the nest – back to the basement room he had lived in as a teenager. Sheila would try to cheer him up with a nice supper, which Jim soon came to expect – watching sports and drinking beer in the basement until his food was ready. Jim began drinking heavily, and sometimes his fury and despair would explode. After coming home from the bar one night, he kicked a hole in the living room wall, shouting obscenities as he clomped down to the basement.*

psychological and financial forms. Victims often still value the relationship with the trusted person who is causing them harm, says Groh. Thus, they may be reluctant to disclose abuse and may minimize, deny or hide it. Victims may be afraid that their child will end up in jail. Or they may simply feel that the legal and health care systems won't be able to help.

Sheila knew Jim would never hit her. Still, she was afraid. His outbursts were unpredictable. And he was asking her for money constantly, without mentioning when, or if, he would pay it back. He had asked to see Sheila's will and

Sheila visited her family doctor about her headaches. As the visit was about to end, the story of her son, and her own predicament, spilled out. Sheila's doctor knew about the elder abuse project and referred Sheila.

The circle process is voluntary, and both the victim and harmer are asked to bring "supporters." All participants tell their stories, after which the group works on achieving consensus on a solution. The solution often involves an apology and a safety plan. Repairing the harm might also involve financial compensation or community work.

Groh notes that a person with a drug or alcohol problem would need to address that issue before coming to the circle, for example, by attending counselling or Alcoholics Anonymous.

One of Jim's former colleagues had told him about a weekly AA meeting. Jim went to meetings to deal with his drinking problem before attending circle. At the first circle, Sheila spoke about her love for her son and her intense sorrow for his problems. With a friend at her side, she also spoke about her fear of Jim's unpredictable behaviour and uncertainty about his stay at her home. Sheila was well into her '70s, and on top of all the other stress, preparing meals, doing Jim's laundry and housecleaning were taking a toll. Sheila also explained how Jim's financial problems were now her problems as well.

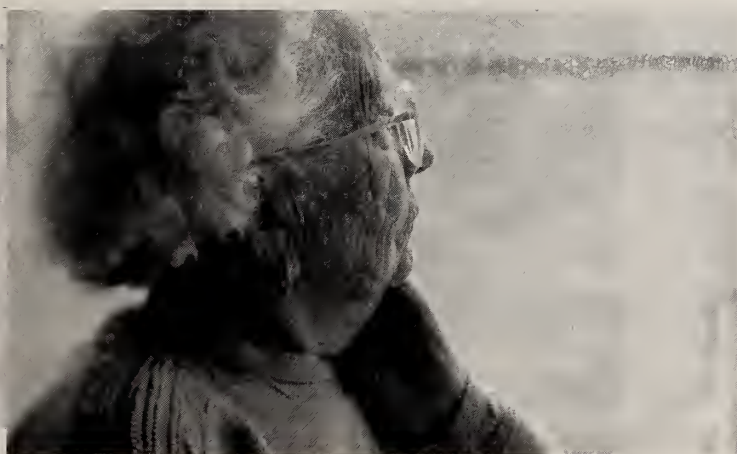
Jim apologized to his mom. He admitted he had "hit bottom" and had taken things out on her. He wanted to get his life back together and agreed that couldn't happen if he continued to live with Sheila. The group reached a consensus on several key items, including a repayment schedule, a move-out date, a list of supports for Sheila and a date to meet again to monitor progress.

"Often our legal system focuses on the past in these kinds of cases – to establish guilt or innocence," says Groh. "We hope to be able to use this approach as a model that many communities can use to look to the future – to repair harm and rebuild relationships."

**The story is based on a composite of real themes and situations, but details have been changed to protect confidentiality.*

For more information, contact Arlene Groh, Restorative Justice Approaches to Elder Abuse Project. Arlene.Groh@ccacwat.on.ca

IAN KINROSS



A new program aims to shine a light at the end of the tunnel for seniors like Sheila who are trapped in a cycle of abuse by their adult children or other relatives. The Restorative Justice Approaches to Elder Abuse Project, which opened its doors for referrals in the spring of 2001 in Waterloo, Ontario, uses an alternative approach to the legal system to bring solutions and healing in cases of elder abuse.

The restorative justice concept draws on "family group conference" and aboriginal models of healing, including the "circle" concept. All parties involved – the victim, the harmer and others – are brought together with a professional facilitator to "look at why the abuse happens – its root causes and what can be done to repair the harm and prevent it from happening again," says project co-ordinator Arlene Groh, a case manager and registered nurse at the Community Care Access Centre (CCAC) of Waterloo Region. The goal is to restore relationships, while respecting the rights of everyone involved in the conflict.

An estimated four to eight per cent of seniors experience elder abuse, which can take physical,

suggested that things would be easier if he had power of attorney. Sheila didn't know how long Jim would stay. She wasn't sleeping well and was experiencing severe headaches. She loved her son and wanted the best for him, but she felt totally helpless.

The project, funded by the Ontario Trillium Foundation, has received referrals from a range of sources: health care providers, clergy, police and crown attorneys in the legal system. A crown attorney may refer a case for restorative justice rather than proceed with a charge. Links have also been forged with local agencies, including the Mennonite Central Committee, the Seniors Outreach Program of the Catholic Family Counselling Centre, elder abuse resource teams, a volunteer committee and an elder abuse education group.

Cases are screened at intake to ensure they are appropriate for restorative justice. "Everyone needs to feel safe, so we need to determine that there are no 'red flags,' such as severe or repeated physical violence," says Groh. A screening committee reviews "red flag" cases.

Japan's bumpy road to mental health reform

LESS THAN A DECADE AGO, JAPAN MIGHT have been scolded for having among the world's longest hospitalization times, keeping over two-thirds of its mental health clients behind locked doors and barred windows and lacking treatment monitoring, client legal protection and social reintegration strategies. Then the Japanese government initiated some major changes with the Mental Health Act of 1987. Since that time, Japan has slowly emerged from the darkness with reforms that continue to promote the deinstitutionalization and social rehabilitation of its mental health clients.

At a recent lecture called "Reforming Mental Health in Japan: Current Context and the Role of the Yadokarinosato Community Mental Health Agency," hosted by the Centre for Addiction and Mental Health, guest speakers from Japan's Kwanseigakuin University and the Yadokari Information Centre, Welfare Factory, described some of the current challenges and recent advances made within their country's mental health care system.

As Dr. Mariko Kimura, a sociology professor at Kwanseigakuin University, described, Japan's hurdles are high, coming from a highly centralized system with scarce community resources, insufficient staff, lack of funding, lack of case management services and a high ratio of psychiatric beds. Kimura, who has studied Japan's system compared to the North American model, has noted some cultural similarities and differences.

Kimura reports that a higher number of people with mental illness work in Japan. "Work ethic is very strong, so patients want something structured to do every day, somewhere to go, such as offered in community workshops." The stigma of mental illness is heightened by being unemployed, explains Kimura, especially among males.

She also reports that "Japanese patients tend to live with their families, whereas there are a wide range of living arrangements in the United States for patients." And while both Japanese and U.S. groups studied reported similarly low social support levels, Kimura says that according to her study, "[psychiatric] consumers living in the community in Japan are very functional and seem to show much fewer symptoms than those in the United States. Far more of them can get out of the hospital and

live in the community with additional support than seen in the U.S. case."

Also speaking at the lecture was Kazuyo Masuda, director of the Yadokari Information Centre, Japan's pioneer community-based program in Saitama City (80 km outside Tokyo). Masuda explained that the Yadokari, which recently celebrated its 30th anniversary, was born from the desire of former inpatients to establish a support system to facilitate work and housing opportunities for those discharged into the community. According to Masuda, there has been more government funding available to these individuals since 1990 (prior to this time, the Yadokari was self-funded and often in financial crisis). Combined with changes to the Mental Health Act since 1987, "We are now better able to provide work and housing for these people, and to support them in the desire to live as normal human beings in the community," says Masuda. "To do that, we've set up five strategic locations (life support centres) with housing and work, so

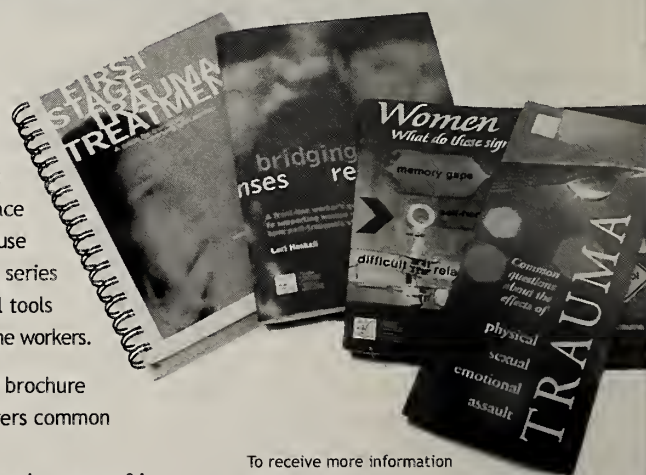
patients have a living base with close proximity to work." The Yadokari spearheaded a number of psychosocial rehabilitation programs in 1990, later adding a social support centre, community workshops and a group home. Essentially, the Yadokari stands as a symbol of perseverance and progress and lends credence to where Japan is headed – toward more community-based services for clients. But Japan has a long way to go considering, for example, that many clients are still involuntarily admitted to psychiatric facilities and are rarely discharged at their own request. As it is, the Family Agreement Commitment law puts the client's decision-making in the hands of relatives, while psychiatric facilities have the right to appeal any client's requests to be discharged. Moreover, says Kimura, "because there is still a strong stigma about mental illness in Japan today, many people don't seek treatment until their illness is advanced, making it harder to treat."

ANGELA PIRISI

Women and Trauma Series

Current literature in the field of women's health suggests that many of the problems women face arise from chronic childhood abuse or neglect. CAMH is producing a series of publications offering practical tools for women, therapists and front-line workers.

- *Trauma: Common Questions* is a brochure for the general public that answers common questions about trauma.
- *Women: What do these signs have in common?* is a booklet for women who might have experienced abuse-related trauma.
- *Bridging Responses* is a booklet to help front-line workers recognize responses to complex PTSD in women's lives.
- *First-Stage Trauma Treatment* is a practical guide for therapists on first-stage trauma treatment.



To receive more information about these resources, please contact Marketing and Sales Services:

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Terrorism forces stress levels to rise



CHERYL ALKON CONSIDERS HERSELF A SAVVY New Yorker, but she has felt unsafe since September 11. She walks around the city, counting building stories. The taller the building, the more likely a target it is. "I think of the buildings three times that height, and how people leapt to their deaths," says the 31-year-old journalist.

In San Diego, California, 4,505 kilometres from Ground Zero, Theresa Morris has different anxieties. She has had to explain to her seven-year-old daughter what a terrorist is and why so many people were killed. "Mostly what worries me is protecting Hannah from feeling afraid, because that first week or so, we got all these questions from her," says Morris. Morris also worries how the resulting economic downturn will affect her family.

These stories illustrate a common point: Across North America – indeed, the world – terrorism has considerably increased stress levels and anxiety. In Canada, an Ipsos-Reid poll in October found that one in three adults reported being stressed. Two-thirds reported having safety fears and 13 per cent reported having trouble sleeping since that fateful day.

The nature of terrorism and vague government warnings to remain vigilant for something so unpredictable are natural stressors, says Dr. Neil Rector, head of the Anxiety Disorders Clinic at the Centre for Addiction and Mental Health in Toronto. People who are stressed by terrorism may dwell on details or turn away from news entirely. They may ruminate on the difference between "real" threats and rumour. They may be plagued by the attacks' viciousness and scale and the shattered American belief in its own invincibility. Another powerful stressor: the media that bring people right into the events as they unfold with tremendous detail.

"Some people find themselves acting fearfully – they're afraid of flying or of opening their mail," says Dr. David Tolin, director of the Anxiety Disorders Center at the Institute for Living, a mental health facility in Hartford, Connecticut.

Dr. Wendy Levy, a psychiatrist in Westport, Connecticut, has also witnessed the psychological fallout of the attacks and people's attempts to cope: "I see denial and anxiety, and I've also seen people seeking refuge in their very structured lives."

The attacks may have a stronger psychological effect on people already vulnerable to stress. Many of Levy's clients are delving more deeply into what brought them into therapy in the first place. Other clients who are recent immigrants talk about returning home. "They left their homes to come here because here it's supposed to be more stable," says Levy. "But an immigrant's life is really tough, and these attacks broke the camel's back."

While it is natural to experience some stress and anxiety around such traumatic events, some people may develop acute stress disorder (ASD), a disturbance newly classified in the DSM-IV, the diagnostic manual used by mental health professionals. ASD tends to be time-limited: symptoms such as feelings of numbness or terror, intrusive thoughts, pervasive anxiety and vivid nightmares surface within four weeks of the trauma and abate after about one month.

Yet the events of September 11 haven't caused – and aren't expected to – an epidemic of mental health problems. "Although most people feel anxious, it's not likely to lead to psychiatric disturbances," says Tolin. But while most people will not encounter lasting psychological effects, one feeling will linger – a nagging uncertainty and a new sense of the frailty of life. "I'm trying to live my life as I did before," says Alkon. "But maybe with a new reality to it – that terrorist activities can happen in my city and in my country and that they can happen at any time."

NICK SAMBIDES, JR.

If any of these symptoms persist beyond two weeks after the trauma, seek professional help:

- changes in eating and sleeping habits
- physical problems such as headaches and stomach aches
- inability to focus or concentrate
- lack of interest in previously enjoyable activities
- extreme fear of leaving home

Source: American Psychiatric Association



Research Update

Abuse history prevalent among young substance users

Youths with substance use problems (SUP) report experiences of physical and sexual abuse at almost twice the rate found in the general population, according to a study by the Centre for Addiction and Mental Health (CAMH). Researchers at CAMH interviewed 287 individuals aged 14 to 24 who sought treatment for SUP. Among this sample, rates of reported physical abuse were 59 per cent for females and 26 per cent for males; rates of sexual abuse were 50 per cent for females and ten per cent for males. Among those who reported a history of abuse, females were more likely than males to use substances to cope with the trauma. Substance use was particularly associated with anger-management problems, although it was not clear whether using substances was a coping mechanism or whether it triggered the anger. The findings indicate the need for clinicians to ask youths with substance use problems about trauma histories.

Canadian Journal of Psychiatry, September 2001, v. 46 (7): 617-621. Bruce C. Baille et al, Youth Addiction Service, University of Toronto, Centre for Addiction and Mental Health, Toronto, Ontario.

Cannabis-induced cognitive impairment may be reversible

Cognitive impairment among heavy marijuana users does not appear to be permanent, but may be a reversible phenomenon associated with recent use. Massachusetts researchers tested 63 current heavy users of marijuana, 45 former heavy users and 72 control participants. The current heavy users had smoked marijuana at least 5,000 times in their lives and continued to smoke marijuana daily. Former heavy users reported at least 5,000 lifetime uses but no more than 12 in the previous three months. Controls reported no more than 50 lifetime uses. Following an initial battery of neurophysiological tests, participants were required to abstain from marijuana for 28 days. Follow-up testing of various cognitive functions was done on

days one, seven and 28. Current heavy users had lower scores than controls on word recall tests up to day seven, but not on day 28. Differences on other tests were minor and transitory. Former heavy users showed no difference from controls on any test on any day. These results suggest that heavy marijuana use may result in cognitive impairment that lasts for days or weeks, but that this deficit is not detectable after a month of abstinence. However, the authors did find that both current and former heavy users had lower educational attainment, income and verbal IQ than controls, which may be the result of chronic intoxication.

Archives of General Psychiatry, October 2001, v. 58 (10): 909-915. Harrison G. Pope, Jr. et al, Biological Psychiatry Laboratory, McLean Hospital and the Department of Psychiatry, Harvard Medical School, Belmont, Massachusetts.

Racial differences found in women with binge eating disorder

White women in the United States appear to be more than eight times more likely than black women to have a history of bulimia nervosa. Researchers with the New England Women's Health Project studied 150 women with binge eating disorder (98 white, 52 black) and 150 healthy comparison women. They found that white women with the disorder were more concerned with body weight, shape, eating and dietary restraint than black women. These findings may explain racial differences in rates of bulimia nervosa. Levels of concern among comparison participants of either race were dramatically lower. Black women with the disorder were less likely than white women to have received treatment for an eating problem. For both black and white women, binge eating

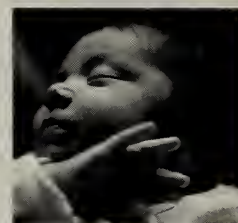


disorder was associated with higher levels of mood and anxiety disorders. White women were almost twice as likely to have histories of alcohol and drug abuse or dependence. The researchers conclude that white and black women have a similar risk of developing binge eating disorder, but that white culture's obsession with thinness may place white women at greater risk of developing bulimia nervosa.

American Journal of Psychiatry, September 2001, v. 158 (9): 1455-1460. Kathleen M. Pike et al, Department of Psychiatry, Columbia University, New York, New York.

Stress lowers success rate of infertility treatment

Stress can reduce the success rate of infertility treatment by as much as 93 per cent, according to research from the University of California in San Diego. Researchers studied 151 women aged 26 to 49 who underwent in vitro fertilization or gamete intrafallopian transfer at seven infertility clinics in southern California between 1993 and 1998. Participants were interviewed to determine levels of stress, mood, anxiety, expectations of success and social supports at the time of their first visit to a clinic and at the time of the procedure. Stress levels at first visit were significantly associated with the likelihood of a successful pregnancy, but stress levels at the time of the procedure were not. Women with the highest levels of stress at the first visit were 93 per cent less likely to deliver a child than women with the lowest stress levels. Women who were optimistic about their chances of success were more likely to give birth. Increased levels of anxiety, hostility and depression also reduced rates of successful treatment. These findings suggest that the critical time for intervention to reduce stress is at the outset of treatment rather than at the time of the procedure. This could be achieved through counselling, support groups or education.



Fertility and Sterility, October 2001, v. 76 (4): 675-687. Hillary Klonoff-Cohen et al, Department of Family and Preventive Medicine, Division of Epidemiology, University of California-San Diego, La Jolla, California.

Tobacco shows no effect on anxiety or concentration



Smokers often claim that tobacco has a calming effect or that it sharpens their minds. However, researchers at the University of Surrey in the United Kingdom found that these effects may be illusory. Forty-five individuals who smoked an average of 16 cigarettes a day were asked to complete two rapid visual information processing (RVIP) tasks separated by a ten-minute break. To induce stress, researchers told participants that their behaviour and facial expressions would be recorded. Anxiety and stress levels were tested at the outset and after each task. During the task break, half of the participants were allowed to smoke a cigarette, and half of each smoking and non-smoking group was given a distraction in the form of a music video. The RVIP tasks significantly increased participants' anxiety and stress levels, but neither smoking nor the distraction reduced stress during the second task. Furthermore, smoking did not enhance cognitive performance during the second task. Previous studies that found a positive effect of smoking on anxiety and concentration have typically examined participants deprived of tobacco prior to testing, in which case the positive effects may have been due to the reversal of withdrawal symptoms.

Addiction, September 2001, v. 96 (9): 1349-1356. Mireille Herbert et al, Smoking Cessation Services, Barnet, Enfield and Haringey Health Authority, Barnet, U.K.

Risk for criminal behavior detectable at age three



Behaviour problems in children as young as age three can indicate an

increased risk of criminal behaviour in adult life, say researchers at the University of Southampton in the United Kingdom. They examined the criminal records of 828 adults aged 23 or 24 who were initially assessed at age three as part of an epidemiological study. The presence of management difficulties and elevated activity levels at age three significantly increased the likelihood of convictions for criminal offences as adults (after 17th birth-

day). Individuals who had problems with temper tantrums at age three were more likely to be convicted of violent offences as adults. Enuresis and soiling initially showed associations with adult criminality, but this was only because they are more common in boys than in girls. Together with elevated activity levels, externalizing behaviours such as temper tantrums and management difficulties may represent "early manifestations of a continuing behavioral style that lasts into adulthood." However, the authors caution that the accuracy of predictions based on such behavioural profiles is limited, and targeting of services at specific individuals is not justified given the costs to children and their families of an erroneous identification.

British Journal of Psychiatry, September 2001, v. 179: 197-202. Jim Stevenson and Robert Goodman, Centre for Research into Psychological Development, Department of Psychology, University of Southampton, Southampton, U.K.

For schizophrenia, anxiety and depression key to quality of life

Quality of life among people with schizophrenia may be more closely related to levels of anxiety and depression than to the core symptoms of the disorder such as hallucinations, delusions and anhedonia. This is the finding of a study of 63 recently stabilized outpatients with schizophrenia or schizoaffective disorder at a New York hospital. Symptoms and quality of life were evaluated using standardized interviews. More severe depression and higher levels of anxiety were associated with lower satisfaction with general quality of life, daily activities, health and social contacts. Depression was also associated with dissatisfaction regarding finances, while anxiety predicted satisfaction with family contacts. Of the core symptoms of schizophrenia, only anhedonia/asociality was significant, affecting satisfaction with general quality of life, daily activities, family, health and social activities. None of the other core symptoms were strongly associated with quality of life. The authors conclude that direct treatment of symptoms of anxiety and depression in people with schizophrenia would improve their life satisfaction.

Schizophrenia Research, September 1, 2001, v. 51 (2-3): 171-180. Jonathan D. Huppert et al, Department of Psychiatry, Weill Medical College of Cornell University, New York Presbyterian Hospital, White Plains, New York.

Men and women gamble for different reasons

A comparison of 349 men and 213 women who gamble found that gender differences in the motivations behind gambling underlie significant differences in the problems resulting from gambling. Study participants were callers to a gambling helpline interviewed by researchers at Yale University in 1998-1999. Males who gamble were more likely than females to report problems with strategic or "face-to-face" forms of gambling such as blackjack or poker. Females who gamble were more likely to report problems



with non-strategic, less personally interactive forms of gambling such as slot machines or bingo. The men in the study were more likely to have a drug problem or to report an arrest related to gambling, while women were more likely to report receiving mental health treatment unrelated to gambling. These results support the findings of previous studies that women are more likely to gamble as a means of escape from distressing problems, while men tend to gamble for the thrill of competitive risk-taking for large stakes. Given these differences in motivation and resulting problems, different strategies may be needed to treat men and women with gambling problems.

American Journal of Psychiatry, September 2001, v. 158 (9): 1500-1505. Marc N. Potenza et al, Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut.

MARK DE LA HEY

Polish researcher wins prestigious international award

DR. JACEK MOSKALEWICZ HAD NEVER expected that the Department of Studies on Alcoholism and Drug Dependence (DSADD) at the Institute of Psychiatry and Neurology in Warsaw, Poland, would become a big part of his life.



A sociologist by trade, Moskalewicz was being held responsible for some "industrial unrest" at his previous workplace, the Institute of Organization of the Machine Industry, where he had worked as a researcher, and he had been fired as a result.

At that time – the late '70s – public perception was that alcohol research "was associated less with research and more with teetotalism," explains Moskalewicz from his home in Warsaw. While Moskalewicz did not expect his professional orientation to be put to good use at the DSADD, he felt it was a safe, politically neutral place to spend a year or so.

A quarter-century later, Moskalewicz is still at the DSADD, now as its principal investigator, and in May 2001 he was honoured with the Jellinek Award for his extensive body of work.

Named after E.M. Jellinek, an epidemiologist who brought the study of alcohol dependence into the realm of scientific research, the Jellinek Award is the most prestigious international award in the addiction field. Moskalewicz was chosen for his cutting-edge work on the construction of drinking as a

social and moral problem, particularly in the context of social and political transition.

"It would be easy but superficial to focus on alcohol as a chemical compound," says Moskalewicz. "But the psychopharmacological characteristics are probably less important in

terms of the consequences of drinking than the cultural definition of the problem." Alcohol research is a kind of lens through which you can observe wider processes and social and cultural developments. By looking at alcohol, you slowly come to a better understanding of *your world*."

This observation of the interdependence of societal factors leading to and from alcohol dependence piqued Moskalewicz's interest at the DSADD. His ideas dovetailed nicely with his previous education and training, and the direction of his subsequent research coincided with a larger sea-change, both in the study of alcohol dependence, and in the social and political climate in Poland as the Communist regime wound down. "This particular perspective [societal factors in alcohol dependence] proved to be very useful for me to follow and understand dramatic social changes that have affected Poland since the beginning of the 1980s," Moskalewicz notes.

His line of research has taken him through scores of studies both in Poland and internationally, including a comparative project

between 1979 and 1982 called the International Study of Alcohol Control Experiences, and has led to publication or co-publication of more than 100 papers, many of them focusing on social policy surrounding alcohol and drug consumption. "It is a common experience of many cultures that alcohol and drug problems are as much social constructs as epidemiological 'facts,'" says Moskalewicz. "For good policy, you need to better understand how alcoholism appears and disappears from the public view. The way people construct the problem in their minds is more important than public consumption."

In his native Poland, Moskalewicz is often asked to advise on alcohol and drug policies on a governmental as well as a community level, and is consulted on the drafting of relevant legislation. Currently, he is involved in drafting a new national program for the prevention of drug abuse in Poland.

Internationally, Moskalewicz is co-founder of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, an organization with a membership of 30 countries whose main mission is to support comparative alcohol studies. He is also a member of the World Health Organization's panel of experts on alcohol and drugs.

"This has been a period of tumultuous change in his home country," notes Dr. Robin Room, professor and director at the Centre for Social Research on Alcohol and Drugs at Stockholm University in Sweden and a member of the Jellinek Award selection committee. Room explains that "Moskalewicz's work shows that alcohol policies were often an important public arena in which these changes were fought out in Poland, and thus has contributed to an understanding of the symbolic weight of alcohol issues. On the other hand, his work also shows empirically the effect of the changes in policies on rates of alcohol-related problems in the population, contributing substantially to the scientific literature in this area." Room adds that more recently, Moskalewicz has insightfully analyzed the changing fortunes of the points of the triangle of the state, the market and civil society, particularly in the current transition period in the formerly communist countries.

TAMSEN TILLSON

Ethnoracial support groups address cultural needs in mental health

BY VICKI O'BRIEN

MEETING THE MENTAL HEALTH NEEDS OF PEOPLE from diverse cultural backgrounds is a big challenge for Canada's mental health care professionals. Language, cultural, racial and religious differences can be barriers to seeking out and receiving effective support and treatment that are easily accessible to the mainstream population.

Helping to fill this cultural gap are a growing number of self-help and peer support programs across Canada that provide linguistically appropriate, culturally relevant support and information in the areas of mental health and addiction for people of diverse ethnoracial backgrounds. Most of these programs run in Toronto, home to Canada's largest immigrant population.

One such Toronto group is the Chinese and Southeast Asian Consumers/Survivors Self-Help Centre (C-SACC) which offers peer support groups, life skills training and social activities for Chinese, Vietnamese and Cambodian mental health consumers. Through C-SACC programs, clients, most of whom are immigrants referred by mental health professionals, can discuss mental health issues in their own language and with a shared understanding of the cultural values and beliefs that shape perceptions and experience of the mental health care system.

"In other self-help groups, Asians might become confused when issues are discussed from a North American perspective," says Raymond Cheng, executive director of C-SACC. "North Americans might not necessarily have the same issues of family stigma and obedience to authority that exist in our culture and that affect how we view mental illness and professional treatment. In our groups, people know where you're coming from — we share a common cultural experience."

Cheng's observations reflect the findings of research conducted through the Culture, Community and Health Studies program (CCHS) at the Centre for Addiction and Mental Health, which found that Chinese-born families wait longer to seek treatment after a first psychotic episode for various cultural reasons, such as those cited by Cheng. The CCHS program grew out of the recognition that these cultural barriers need to be addressed to provide effective treatment of mental health and addiction problems.

Ethnoracial self-help and support groups offer support in a way that health care professionals might not be able to. "Professionals are supportive, but they offer limited care," says Cheng. "They often don't know the culture and the specific health care issues that accompany it. We know one another much better than a therapist because we don't have the cultural barriers among ourselves that divide non-Asian therapists and Asian clients."

Modeled on programs successfully targeting new immigrants and refugees, ethnoracial self-help programs provide Eastern and non-medical perspectives on mental health. Western medicine may indeed alienate clients from diverse ethnoracial groups. For example, spirituality, which is an important aspect

of healing in many cultures, has traditionally had no place in western medicine.

Across Boundaries, a Toronto-based mental health centre that provides a range of supports and services to people of colour from Arab nations, Africa and the Caribbean, tries to address the needs of various cultural groups through its holistic approach to mental health. A wide range of standard support programs, including family and peer support groups and drop-in programs, are enhanced with alternative and complementary healing including yoga, Qi Gong [exercises combining breathing, movement and meditation], ayurvedic medicine, shiatsu and art and music therapy. "We encourage people to find strength among themselves," says Martha Ocampo, co-director of programs and services. "Consumer survivors lead peer support groups in a number of different languages and they're generally extremely lively."

How do agencies like Across Boundaries judge success? Last year, of the 99 consumers attending its programs, only four returned to a hospital or mental health facility.

At C-SACC, peer support group members, particularly those who have been in Canada for some time, encourage one another to become active participants, rather than passive recipients, of the health care system. "We encourage one another to become more assertive and proactive, to know there are options beyond the limits of our culture," says Cheng.

Toronto's South Asian Women's Centre (SAWC) provides another example of culturally sensitive support services. SAWC is an information and counselling service that addresses mental health issues of South Asian women who may be feeling stress, isolation and depression. In partnership with the Canadian Mental Health Association, SAWC offers weekly peer support groups in Tamil, Hindi, Urdu and Punjabi.

The cultural and religious beliefs of Asian women are seldom recognized in the planning and delivery of psychiatric and community support services, according to Jayanthie Reynold, settlement co-ordinator at SAWC. As a result, they may under-utilize mental health services. "For example, the standard medicines used to treat mental illness are not tested on South Asian women. What might be a normal dose of a certain antidepressant can make our clients feel suicidal. As a result they are afraid to take them." Women meet weekly to discuss issues important to them and to provide mutual support and share information and resources.

The challenge to provide culturally relevant health care is growing. Through education and multicultural collaboration, mental health professionals will transcend cultural barriers and provide more effective mental health and addiction services to diverse communities. ■



On-line self-help groups break down barriers to care and support

BY NATE HENDLEY

YOU'RE A TEENAGER WITH A SEVERE PHYSICAL disability that makes you self-conscious in social settings. Or maybe you're a woman with an addiction who is uncomfortable dealing with a support group dominated by men. Perhaps you suffer from depression but work odd hours or live in an isolated community that makes attending regularly scheduled self-help meetings difficult.

How do you connect with your peers to share information, give and receive support and discuss issues that concern you? Increasingly, the answer is – the Internet. The explosive growth of the World Wide Web has been accompanied by the rise of on-line self-help groups, with members communicating via the Internet or other on-line services in the privacy of their homes or through public Internet connections.

Like traditional support groups, these on-line organizations deal with addiction, mental health issues and disability. "Self-help groups are about people helping themselves by helping each other," states Roya Rabbani, executive director of the Self Help Resource Centre, a Toronto-based co-ordinating body for support organizations. "They are based on experiential learning. You have experienced something on a specific issue or problem and you share it."

While on-line self-help groups share many of the same benefits as traditional groups, on-line technology is dramatically increasing the number, accessibility and capabilities of self-help groups. It has done this by enabling people to overcome barriers that previously kept them from participating in traditional face-to-face groups.

The Internet setup offers unique benefits, says Gerry Cooper, program director for the Sudbury office of the Centre for Addiction and Mental Health. Cooper conducted a study of a now defunct on-line gambling self-help group known as GAweb. "Most people initially came to this peer-support group because of its convenience," says Cooper. "Sites like GAweb are available 24 hours a day, seven days a week, regardless of the weather or geography or what ordinarily might pose as obstacles, such as childcare, anxiety or fears about confidentiality." Unlike a face-to-face encounter, a person's gender, ethnicity

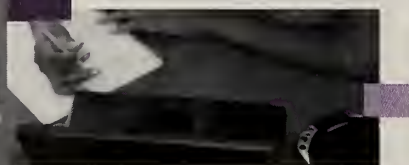
and economic status are difficult to discern in cyberspace. The anonymous nature of the medium is also highly appealing to people who are intimidated by public speaking or embarrassed by their problem. On the Internet, "everyone looks the same, so prejudices based on age, appearance or disability disappear," notes Dr. Arlette Lefebvre, a psychiatrist at Toronto's Hospital for Sick Children.

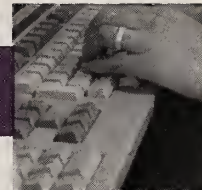
Lefebvre helped found Ability OnLine, a Toronto-based Internet support site for young people with disabilities and chronic illnesses. The site was launched in the early 1990s to let clients access health information via a Bulletin Board System, a predecessor of the World Wide Web. Today, youth around the world use Ability OnLine to send e-mail to friends, participate in real-time chats or discuss various issues. Through Ability OnLine, users can overcome any stigma they might feel about being disabled. Long-time Ability OnLine member Aimie Rout, a 25-year-old resident of Whitby, Ontario, has suffered from a recurrent brain tumour since 1989. Rout describes Ability OnLine as "a God-send." "It gave me a sense of belonging because I was not accepted by my peer group at school," recalls Rout.

Fear of rejection and social embarrassment may also make people with addictions and mental illness reluctant to approach traditional support groups. Nearly three-quarters of the respondents in Cooper's study indicated they avoided face-to-face support groups because of negative associations connected with problem gambling.

While Marie, a southern Ontario resident with a gambling problem, wasn't part of Cooper's study, she says that stigma was a major stumbling block in getting help. "I had always been responsible with my money until gambling came along. So it's very difficult to come out in the open and admit to having a problem," states Marie, who would rather not give her last name. The gender imbalance in the support meetings she attended didn't make things any easier. "The reality of Gamblers Anonymous meetings is that the vast majority of attendees are male," says Marie. "That makes me uncomfortable." Marie eventually turned to GAweb, where she could

**On the Internet,
"everyone looks the same, so prejudices
based on age, appearance or disability
disappear."**





communicate with peers in a non-gender-specific format. She also found the chat room helpful for making personal statements about her gambling problem. "Perhaps admitting it on-line is easier," says Marie.

Lori Swagers, a 46-year-old resident of Oshawa, Ontario, who suffers from agoraphobia, has had a similar experience with a Web site called Lifeline. She first encountered the site while searching for help in the midst of a panic attack. The Lifeline site offers information and a message board for people who suffer from anxiety disorders. Like Marie, Swagers would rather go on-line than take part in a support group that meets in person. "I absolutely prefer the site atmosphere," she says. "I am very uncomfortable discussing my problems with people face-to-face. ... I feel they would be judgmental, even though I know this is not really true."

The respondents in Cooper's GAweb survey described similar experiences. "Many participants reported feeling they could be more honest in an on-line group versus face-to-face," says Cooper. The format also had an unanticipated benefit – it encouraged greater self-analysis. "Some had to work harder to find the correct words to reflect their feelings, and this caused them to perhaps search deeper within themselves," explains Cooper. Roughly 70 per cent of study respondents stated that GAweb has made a difference in their gambling behaviour. Over three-quarters of participants said they would seek out additional forms of Internet-based assistance.

Despite these impressive statistics, such groups are far from perfect. "There are advantages in meeting face-to-face," says Rout from her home in Whitby. Such gatherings offer a tactile element that's missing on-line, she notes.

And while the on-line medium may improve accessibility to support groups, for some, accessibility remains an issue. Owning a computer or living in a community that offers locations with Internet access is required. Knowing how to use high-tech tools and being fluent in the primary language of any Internet organization are also necessary.

And while the anonymity of the Internet offers the safety that some people need to seek help for a problem, it may also

encourage irresponsible and even dangerous behaviour. One Web community called Anorexic Pros posts this introductory message: "We're all here to support and learn together, so everyone is welcome. However, if you are in any way against anorexia/bulimia, our group is not for you."

Still, the general consensus is that cyberspace self-help groups are here to stay. As Dr. Tom Ferguson, a writer and physician often referred to as the "father of on-line self-help," notes, Internet-based medical services are becoming hugely popular. An article on his Web site at fergusonreport.com describes a survey he conducted in 1999. Ferguson sent a questionnaire to 1,000 members of an organization called the Sapient Health Network, which provides on-line services for people with chronic or serious illnesses. "We asked these on-line self-helpers which of three health resources – their on-line support groups, specialist physicians or primary care doctors – they found most useful in 12 dimensions of health care," says Ferguson. "The 191 self-helpers who responded rated on-line support communities as more helpful than either specialists or primary care doctors in 10 of the 12 areas." These areas included "best in-depth information on my condition," "best help with emotional issues," "most convenient" and "most compassion and empathy." "Many respondents made it clear that as they were dealing with serious medical problems and often felt overwhelmed, isolated and discouraged, their on-line community served as an important and treasured haven – a place where they feel welcomed, valued and understood," says Ferguson. These findings echo those of Cooper's study. Both groups said that Internet support sites provide hope, help and, perhaps most importantly, an invaluable outreach service. "On-line assistance may be a wonderful way of getting people into treatment" says Cooper.

"People who otherwise would not come forward and who in all likelihood would suffer in silence." ■

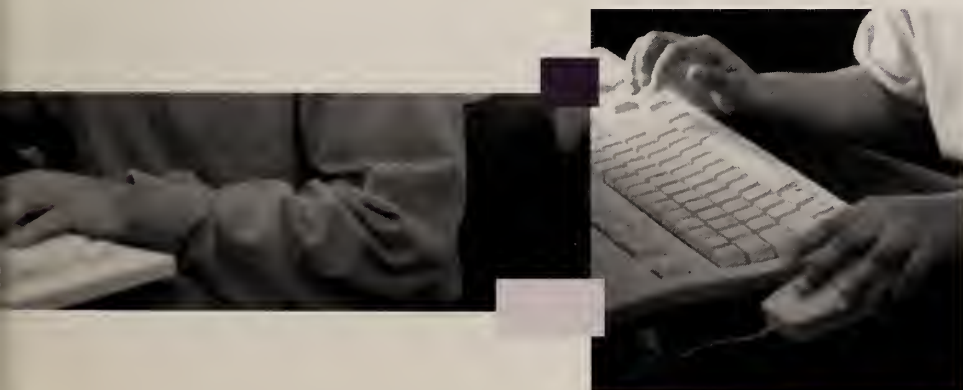
A SELECTION OF ON-LINE SELF-HELP GROUPS

HEALTHY PLACE – www.healthyplace.com – offers chat rooms, forums and on-line information for people with addiction or mental health problems

LIFELINE – designandcopy.ca/lifeline – on-line support group for people with anxiety disorders – offers message board

NARCOTICS ANONYMOUS – basicwebpage.org/index.html – offers chat rooms, on-line meetings and forums

WALKERS IN DARKNESS – www.walkers.org – offers chat rooms, forums, web conferencing and mailing lists for people with depression or bipolar disorder



Sex offenders find hope through community support program

BY TAMSEN TILLSON

THERE IS A SEX OFFENDER IN HAMILTON WHO calls Ed Rogalski "dad." But Rogalski, a retired school-teacher, is not Steve's* father; he is a volunteer with a faith-based community support program that helps sex offenders following release from prison.

Such support for sex offenders is rare. Government-funded assistance programs exist for sex offenders released on bail, but for those who serve out their entire sentence, known as warrant expiry offenders, there is "basically nothing," according to Eileen Henderson, project manager of Circles of Support and Accountability, a project of the Mennonite Central Committee (MCC), funded by Correction Services Canada and based in Kitchener, Ontario. Yet due to the nature, severity or duration of the crime, these individuals are considered at high risk for reoffence.

Every year, 70 of these warrant expiry sex offenders are released in Ontario. Often uneducated and with few employment skills after many years in prison, they are released into poverty with nowhere to live and few prospects for work or relationships – the ultimate pariahs. "I had to come out of the

trunk of an OPP squad car," recalls Henry*, one of the group's first clients. "I was under 24-hour surveillance in Peterborough, was chased to Toronto and finally went to the then Clarke Institute of Psychiatry. I had a really tough time keeping work. People would recognize me and get rid of me."

The MCC, which has a history of tackling issues around restorative justice, took up the challenge. Circles of Support and Accountability was built on the notion that a male sex offender who has a steady job, place to live, network of friends and regular appointments with a therapist is less likely to reoffend than one who is rejected by frightened and angry communities and denied treatment, housing and a job.

The prototype was designed eight years ago by a Mennonite pastor, a Toronto CSC chaplain and an MCC staff worker in response to the imminent release of Henry in Toronto and another high-profile, high-risk sex offender in Hamilton. The program is based on a mental health model in which a team supports and encourages the offender, known as the "core member," to rebuild his life and remain out of trouble. The member is supported by

four to seven volunteers from various faith traditions. Each circle, which generally meets once a week, is tailored to the needs of the core member. Volunteers have some weekly one-on-one contact with the core member – going apartment hunting or to lunch, or accompanying the member to therapy. Ideally, the core member and volunteers become friends, attending family barbecues or one another's weddings. "Without the circle, I would have been lost," says Steve. Indeed, Rogalski has become a father figure to him. "Steve doesn't have real family, so he likes us to be his family," says Rogalski. "I don't find it that strange. He's emotionally starved."

"People sometimes say we're coddling the member," says Rogalski. "Well, we don't. When we're in a circle, we can get fairly brutal, challenging his behaviour or questioning his thinking." The living certainly isn't easy. Steve is a workfare participant, pulling in a welfare cheque of \$521 per month, \$420 of which goes toward rent. He has no phone and depends on food banks.

Core members must sign a covenant, committing themselves not to reoffend and to follow rules, such as attending AA or staying away from children. They are expected to be open and honest, and provided they are not breaking the law or any of their release conditions, they receive confidential support in return. "You have to be willing," says Henry, who is approaching seven trouble-free years. "I was willing to pay any price to be happy, joyous and free; some aren't."

A successful circle can dissolve in as little as a year if the core member has reintegrated into the community. But some circles, such as Henry's, continue indefinitely, until the member is ready to leave. However, not all circles are successful. "I had one experience that wasn't very good," remembers Rogalski. "There was one man who was very bright, but couldn't be trusted. The circle broke up because he got into trouble and was locked up again."

What started as a pilot project in Hamilton, Kitchener and Toronto has now, eight years later, become a full-fledged program extending well beyond the original purview of the MCC. There are between 50 and 60 circles, all based on the MCC model, across Canada, according to David Molzahn, special advisor to the CSC's director general of chaplaincy.

Signs of acceptance, although small, are beginning to appear at the community level. While communities are at best wary of the prospect of a sex offender in their midst, people respect the Circle of Support and Accountability, says Henderson. Last year when the group was involved with one high-profile sex offender, Henderson says the public's reaction to the circle was promising: "We do not want these people in our community, but if they have to be here, we're glad you're doing something." ■

*Not their real names

Preliminary findings of a five-year study of the Circles of Support and Accountability pilot project indicate that the circle reduces recidivism by more than 50 per cent and that reoffences are less severe than in the general warrant expiry population. Researchers at the Central Ontario Parole District selected a sample of 30 circle members from the Toronto, Hamilton and Kitchener areas. Over five years, they compared recidivism rates among these men with a group of about 1,600 men across Canada and the U.K. About 25 per cent of circle members – seven or eight men – would have been expected to reoffend. Only three members had reoffended by the end of the five-year period.

**Q
&A****Common Questions about
12-Step Groups for Addictions****What is a 12-step group for addiction?**

Twelve-step groups are peer-led support groups for people recovering from addictions that emphasize abstinence and the central role of affiliation with other recovering people. These groups believe that having a new social system to replace the former substance-dependent lifestyle strongly enhances recovery. Alcoholics Anonymous, the world's largest 12-step group, describes itself as a "fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others recover from the addiction." The 12 steps describe the attitudes and activities that the founders of 12-step programs such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous believe are important in helping to overcome addiction.

Is 12-step treatment or self-help?

Twelve-step groups are not treatment programs – they do not conduct assessments, arrive at diagnoses, dispense medications, write treatment plans, provide case management or do group or individual therapy. Rather, the programs focus on recovery, where discussion revolves around solutions to achieving and maintaining abstinence, not group psychotherapy or counselling.

Twelve-step groups are often used to complement and enhance professional treatment. Many therapists encourage substance users undergoing professional treatment to attend 12-step meetings throughout treatment and after its termination. Participation prior to entering initial treatment may provide an excellent preparation and education for the individual. Participation during treatment may result in improved compliance and lower dropout rates. Self-help groups extend far beyond a period of relatively brief professionally run treatment and may serve as a good support to prevent relapse. Development of a stable support system prior to ending professional treatment may ease the transition out of treatment and into abstinence.

If I join a 12-step group, can I ever use the substance again?

Twelve-step groups are based on the belief that addiction is a chronic, progressive, irreversible disease based on a biological difference that causes people to crave the substance and lose control of their consumption. The 12-step philosophy states that the addiction can be controlled, but it cannot be cured. Abstinence is the best way to control the addiction. The mere fact of abstaining from the addiction for months or even years does not mean that the person with the addiction is cured. Rather, 12-step programs encourage members to quit completely and develop a new pattern of healthy, constructive living.

Won't everyone know I have a problem if I join a 12-step group?

Twelve-step programs are based on anonymity. Members are not required to disclose their last name or other personal information. Traditionally, 12-step groups never disclose their association with the movement through any public media. And no one has the right to break the anonymity of another member.

Do I have to believe in God to join a 12-step group?

Although 12-step groups teach the vital role of spirituality in recovery, they are not religious programs. Twelve-step groups claim not to be affiliated with any denomination, sect or specific religious belief. Nor do they require a definite religious belief as a condition of membership. Twelve-step groups have among their membership followers of various religions, as well as agnostics and atheists.

Twelve-step programs are undeniably based on acceptance of one core spiritual value. Group members must acknowledge that the substance has become a power greater than themselves. To control their addiction, members must accept and depend upon a greater power. How members define this power is less important than their

recognition that they are unable to deal with the addiction on their own. For some, this power is God as they individually understand this being. Some members consider the group itself as the power. Others rely on a different concept of a higher power and may find non-deistic directing forces for their life; for example, love, justice or creativity.

What are the alternatives to 12-step groups?

Twelve-step groups are not for everyone. Although they claim not to be religious organizations and can provide support for people regardless of their faith, there is a definite Christian origin to many of the beliefs espoused by 12-step groups that may alienate people who are not Christian. Other people may be uncomfortable with the emphasis on spirituality and powerlessness in general. Still others may disagree with the disease model of addiction. Many self-help groups not based on the 12-step model exist that support abstinence or, alternatively, take a moderation approach in a mutual-support environment. There are also groups that do not emphasize spirituality or powerlessness in recovery.

Information about alternatives to 12-step groups can be obtained through self-help centres and clearinghouses across the country. These organizations are responsible for maintaining contact information for self-help initiatives in a given location. The Self Help Resource Centre of Ontario can provide information about national and international resources for locating self-help groups for various addictions. The Web address is www.selfhelp.on.ca.

HEMA ZBOGAR

Sources: Dr. Dennis James, clinical director of Assessment and General Treatment, CAMH; Jan Parker & Diana L. Guest, *The Clinician's Guide to 12-Step Programs*. Westport, CT: Auburn House, 1999; Stanton Peele & Charles Bufe, *Resisting 12-Step Coercion: How to Fight Forced Participation in AA, NA, or 12-Step Treatment*. Tucson, AZ: See Sharp Press, 2000; Stuart Gitlow, *Substance Use Disorders*. Philadelphia: Lippincott Williams and Wilkins, 2001; www.alcoholics-anonymous.org.

Reviews

The place of coercion in treating serious drug dependence

THIS COLLECTION OF ESSAYS ILLUSTRATES THAT IT IS POSSIBLE TO completely reject legalization and still see much wanting in the U.S. model of punitive drug prohibition. The core-and-centuries-old debate underlying the book's title is – Is the state justified in imposing coercion for an individual's own good? All the contributors come down firmly on the side of justifiable intervention when drug use leads to destructive and socially irresponsible behaviour. The proposed modifications to America's drug policy, reflecting the authors' expertise in psychiatry, economics and criminal justice, focus on the heaviest users of heroin and cocaine. The authors view many conventional approaches to prevention, treatment and enforcement as inadequate and unsuccessful because they do not recognize the diversity of the life situations of people with addictions and their complex problems. The increasingly lengthy periods of incarceration that characterize recent U.S. drug policy are costly and counter-productive. Treatment programs often fail to provide the optimal balance of rewards, punishment, structure and sanctions that foster self-control and the ultimate goal of abstinence. Prevention programs tend to be supported more on political than scientific grounds.

While the authors acknowledge the behavioural description of addiction as a chronic, relapsing condition, they reject the popular National Institute on Drug Abuse conception of addiction as a "brain disease." They argue that addictive behaviour is voluntary, responsive to negative consequences and should not be reduced to "a slice of damaged brain tissue." Rather than the pharmaceutical intervention or even the genetic manipulation implied by the neurobiological model, the psychiatrists in this book support treatment based on integrating care and coercion. While recognizing that quitting drugs can be very difficult, they remind readers of the considerable evidence that most people with addictions eventually do quit – without help. The most effective programs are those that build on structured supports and controls, provide alternative rewarding activities and are reinforced within the community. Addiction is not only a matter of a drug interacting with a particular individual; the outcome is affected greatly by the social/environmental context that fosters the conditions that promote or reduce self-control.

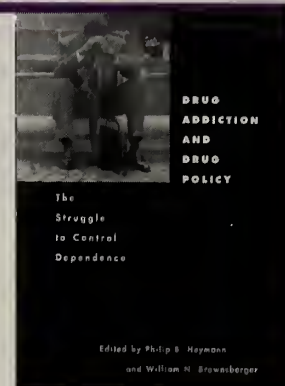
The authors acknowledge that insisting on the voluntary nature of drug-taking invites a punitive, even stigmatizing response, in contrast to the medicalized model that emphasizes helpless victimization by brain chemistry. But, while giving primacy to the addicted person's responsibility for drug-taking behaviour assigning and an important role to the criminal justice system in reinforcing this objective, they are also harshly critical of many common practices. Targeting of low-level dealers, mandatory minimum sentences, widespread drug testing tied to social assistance and severe sanctions resulting from a single failure of drug tests.

Most seriously, the authors acknowledge that the concentration of the war on drugs is concentrated in the poorest neighbourhoods. ("In Massachusetts the poorest 10% of neighbourhoods have drug incarceration rates 56 times higher than the wealthiest 10% of neighbourhoods.") This, combined with the vastly disproportionate arrest of minorities for drug offences, demonstrates serious inequity in the application of drug policy. Yet only one chapter suggests that good social policy might also be good drug policy, despite the example of America's Canadian neighbour, which historically has a lower rate of serious drug addiction problems.

In sum, this is a rich and provocative collection of essays that will be of particular interest to those examining specific innovations such as the drug courts and for those generally honing their thoughts on more effective policy approaches to addiction. For those inclined to resist the "enlightened" coercion favoured in this collection, it will provide a challenge to muster countervailing evidence and arguments.

PATRICIA G. ERICKSON is a senior scientist with CAMH and a professor of sociology at the University of Toronto.

Drug Addiction and Drug Policy: The Struggle to Control Dependence. Heymann, Philip B., Brownsberger, William N. (Eds.). Boston: Harvard University Press, 2001, 273pp., \$39.95 U.S.



Downloaded Getting help on-line

There is an abundance of good health Web sites; many offer a range of aids for help-seekers, from directory-type information for community resources to on-line buddies, forums, chat rooms, message boards and even scheduled, on-line self-help meetings. An example of the latter is **Marijuana Anonymous World Services** at www.marijuana-anonymous.org.

If you are at a loss about where to begin, start with the large, reputable sites that were established to provide virtual communities, such as **Join Together Online** at www.jointogether.org, **Mental Help Net** at www.mentalhelp.net or the **Canadian Health Network** at www.canadian-health-network.ca, all described in previous Downloaded columns.

Join Together Online is a good place to start for substance abuse support. Select *Substance Abuse*, then *Self-Help*, under *Treatment*. You will find links to many resources, including Web sites of self-help organizations. You can assess your drinking on-line through **AlcoholScreening.Org** at www.alcoholscreening.org, a service of **Join Together**. The **Centre for Addiction and Mental Health** provides a similar on-line assessment at www.notes.camh.net/efeed.nsf/feedback.

For mental health issues, try **Mental Help Net**. Select a *Problem* and from there, scroll through the headings to *Online Support*. For example, if you select *Anxiety*, the *Online Support* includes resources such as the **Support Forum** sponsored by **Mental Help Net**, and various chat options.

SHEILA LACROIX

Sober for Good: Learning from those who have been there

ONE OF THE BEST THINGS ABOUT *SOBER FOR GOOD: NEW Solutions for Drinking Problems – Advice from Those Who Have Succeeded* is author Anne Fletcher's refusal to get drawn into the emotionally charged "AA – are you for it or against it" debate. This is by no means a 12-step trashing tome along the lines of Marianne Gilliam's *How Alcoholics Anonymous Failed Me*, nor is it a paean to hard-line "recovery orthodoxy." In *Sober for Good*, Fletcher concentrates on what worked, for whom and why.

Fletcher turned to the real experts, people she calls "masters" – hundreds of people from all walks of life to find out how they resolved serious drinking problems. After all, who would know better what works than those who have succeeded? What she discovered challenges long-held assumptions about alcohol problems. Her book introduces into mainstream thinking the idea that there are many ways to get sober – and stay sober.

Fletcher sets a single standard for defining a master – sobriety maintained for five years. But sobriety means different things. For the vast majority of the 222 masters Fletcher met, sobriety is synonymous with abstinence. But another 10 per cent of masters consume small amounts of alcohol on special occasions, such as family celebrations. A very few have regained control over the amount they consume and could be classified as moderate or light drinkers. It is important to note, however, that most of the masters feel that abstinence is the only safe way for them. Readers also need to know that for people with serious drinking problems, any alcohol consumption is potentially catastrophic.

Fletcher's masters achieved sobriety after having tried and failed with several different methods. They also range in the severity of their problem. Some masters were "functioning drunks," while others were "street" alcoholics. Some recovered in residential treatment programs, while others quit with family support. Not all had to hit bottom in the traditional way before opting for recovery, although some had lost everything to alcohol.

The recovery stories that Fletcher heard expose many of the myths about alcohol recovery. She posed telling questions to the masters: How important is it to admit that you are an alcoholic? If you don't admit that you're an alcoholic, are you always "in denial"? Is the word "alcoholic" a

label that prevents people looking for help sooner? Do you have to join a recovery group? Can you still get sober without faith in a "higher power"? Can you just quit on your own?

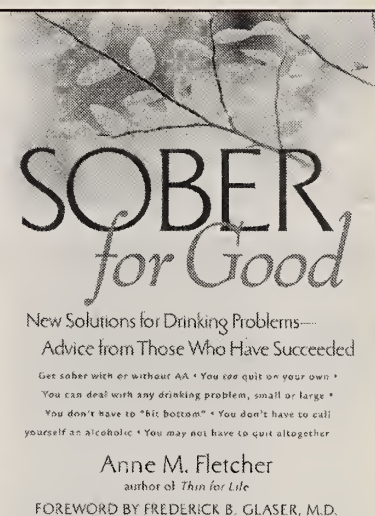
While the book features masters whose alcohol problems varied in severity, *Sober for Good* is weighted toward individuals who have had milder drinking problems – individuals who Fletcher feels are less well served by current treatment options. These are people who AA would not call "alcoholics" and who have traditionally not done well in 12-step programs. Whether these individuals are "in denial" or "not alcoholic" is irrelevant to Fletcher – it's their success that interests her.

Despite the publisher's claim that the book "shatters long-held assumptions" about alcohol recovery, there is little in *Sober for Good* that is scientifically new. It took a lot of courage to write this book in the United States, where 12-step groups and their espousal of abstinence are the norm, but harm reduction approaches have been a reality in Canada (and elsewhere) for almost 20 years. The book, however, is a timely reminder that Alcoholics Anonymous, while still the largest and most available resource, is far from the only option.

While using the familiar technique of collecting inspiring success stories of people who have taken back control of their lives from alcohol, Fletcher backs up these stories with scientific findings. The upshot is that there is no "one size fits all" treatment – whatever works is what you need.

ARTHUR MCCUDDEN is senior information officer at CAMH.

Sober for Good: New Solutions for Drinking Problems – Advice from Those Who Have Succeeded. Anne M. Fletcher. Houghton Mifflin, New York, 288 pp., \$25 US.



Books In Brief

Smoking: Risk, Perception, and Policy

Paul Slovic, ed., Sage Publications, London, UK, 2001.

Smoking presents research based on a large survey of young people and adults probing attitudes, beliefs and perceptions of risk associated with smoking. Divided into five sections, topics include the risks of active and passive smoking, perceptions of risk by adolescents and adults, media influences on smoking, the nature of nicotine addiction and legal and policy perspectives on smoking. The survey data underscore the need for aggressive policies to counter tobacco firms' marketing and promotional efforts and to restrict youth access to tobacco.

Parenting Well When You're Depressed: A Complete Resource for Maintaining a Healthy Family

Joanne Nicholson, Alexis D. Henry, Jonathan C. Clayfield, Susan M. Phillips, New Harbinger Publications, Inc., Oakland, California, 2001.

Based on more than 10 years of research, this unique guide provides strategies and resources that parents with depression can use to encourage and support the healthy development of their children while managing

their disorder. Topics include recognizing how depression affects daily functioning as parents and how it impacts the needs of children. The guide includes checklists and activities to help readers develop new skills and take on challenges in the areas of alternative family situations, child care and legal issues, money and work.

Eating Disorders: Anorexia Nervosa, Bulimia, Binge Eating and Others

Jim Kirkpatrick and Paul Caldwell, Key Porter Books / Canadian Medical Association, Toronto, Ontario, 2001.

Eating Disorders is a comprehensive guide for people with eating disorders, their family and friends. In accessible non-jargon, the authors discuss causes, effects and treatment of various eating disorders. Topics include early warning signs of a developing disorder, genetic predisposition and practical tips on how families can cope. The book is supplemented by case studies and personal insights from people recovering from these problems.

The Last Word

Are we making the most of Alcoholics Anonymous?

BY PETER ARMSTRONG



Editorials do not necessarily reflect the views of the CAMH. We welcome submissions from our readers. For information, contact: The Editor
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33 Russell St., Toronto
Ontario M5S 2S1
tel (416) 595-6714
e-mail journal@camh.net

Small wonder members of Alcoholics Anonymous (AA) are such an odd lot. They have all suffered an emotional cauldron of loneliness, fear, alienation and shame – until they discover that drinking can lift them to dazzling heights of self-confidence. Eventually alcohol – once their friend – turns on them with a vengeance, plunging them into deeper depths of despair. Finally they discover AA and are lit up with hopeful sobriety.

Members start to recover; they notice that everybody seems to be recovering; they swell with pride at the supremacy of AA. But their hopes are deflated once again when they discover that even with AA's stunning success, and with all the research and other treatments developed since its inception, most alcoholics die, either directly or indirectly, from the illness.

This humbling fact is often cited in the search for other treatments. However, in that legitimate search, some critics characterize AA as coercive, moralistic, punitive, religious and exclusive. Some depict it as a cult. Still more unfortunately, some of these mistaken opinions infect otherwise scientific endeavours and public policy, with the result that AA and the treatment it inspires are being marginalized and minimized.

What an utter tragedy of lost lives and wasted money.

It may be useful to review just what AA is and what it has accomplished in its 66 years.

AA is an independent, entrepreneurial, maddeningly democratic, non-profit organization. There are an estimated 2.1 million men and women in 97,000 groups in 150 countries, with 98,000 members in Canada. Membership is entirely voluntary and open to anyone with a desire to stop drinking. Members are found everywhere in the private, public, unemployed and non-profit sectors, representing a broad spectrum of race, ability, colour, religion (and non-religion), age, socioeconomic status and other demographics.

Its basic text, *Alcoholics Anonymous*, with 20 million copies in print, has been published in more than 40 languages and transformed into Braille, large-print format and American Sign Language videos.

AA and AA-inspired programs are the treatment of choice among occupations that require assured success (autoworkers, law enforcement officers, transportation workers and doctors), as well as privately owned American hospitals, which must deliver successful outcomes, within a context of cost-efficiency and accountability.

Studies by independent authorities, notably Harvard psychiatric professor George Vaillant and the U.S. National Institute on Alcohol Abuse and Alcoholism, show that AA works.

AA's friends in the treatment sector have also tested outcomes. For example, studies by Renascent, a Toronto-based resource centre for the prevention, education and treatment of addiction to alcohol and other drugs, show that up to two-thirds of residential clients achieve lasting sobriety two years post-treatment. The key to their success is involvement in AA. A literature review by Rick Csiernik at the University of Western Ontario clearly identifies 12-step residential treatment as an important, effective and cost-efficient approach to the illness. "AA works," says Ontario addiction specialist Dr. Graeme Cunningham. "The science is there."

Members of AA and the other 12-step groups such as Al-Anon and Narcotics Anonymous carry the message of recovery, officially and un-officially, to thousands of schools, workplaces, penal institutions, hospitals, treatment facilities, homes and families. In the Toronto area alone, they run more than 300 meetings a week.

Besides treatment, education and outreach, AA members routinely provide referral, early intervention, withdrawal management and after-care services; make house calls; counsel families and employers; and operate helplines 24 hours a day, 365 days a year.

All this from an organization that accepts no money from government, corporations, special interest groups, foundations or other outside sources. Not only does AA massively reduce the horrendous human and economic damage caused by alcoholism, it accomplishes this and finances its expansion solely through the voluntary donations of its members. AA-connected treatment facilities use that synergy to attract significant resources into the health care system. Last year, for example, 600 volunteers contributed more than 25,000 hours to Renascent. Five hundred individuals, unions, foundations, corporations and families added donations in cash and in kind totalling \$1.87 million.

Given AA's broad and long-term success, its unmatched cost-efficiency, its adaptability, affordability and accessibility, and given the scarcity of precious health care resources, should it not be government policy and practice to maximize use of the 12-step option? To educate addiction and other human services workers about AA and its offspring? To build more programs and services around the 12-step model?

In our legitimate professional efforts to solve alcoholism (and addiction to other drugs) let's not look a gift horse in the mouth. ■

Peter Armstrong is President and Chair of the Board of Renascent, a Toronto-based resource centre for the prevention, education and treatment of addiction to alcohol and other drugs.

Conferences

CANADA

12th Annual Rotman Research Institute Conference, Emotions and the Brain

March 25–26, Toronto, Ontario
Contact: Education Department,
Baycrest Centre for Geriatric Care,
tel (416) 785-2500
fax (416) 785-4215
e-mail conference@rotman-baycrest.on.ca

State of the HART: Habilitative Achievements in Research and Treatment for Mental Health in Developmental Disabilities – A Canadian Report Card

April 18–20, Vancouver, British Columbia
Contact: Interprofessional
Continuing Education,
tel (604) 822-0054
fax (604) 822-4835
e-mail interprof@cehs.ubc.ca

IFPE 2002 9th International Congress: Mental Health Problems in Primary Care – From Research to Practice

May 12–15, Edmonton, Alberta
Contact: Dr. Roger Bland, Chair, Local
Arrangements Committee, IFPE 2002,
Department of Psychiatry, University of
Alberta, Edmonton, AB T6G 2B7
tel (780) 407-6570
fax (780) 407-6804

23rd Congress of the Collegium Internationale Neuro-Psychopharmacologicum

June 23–27, Montreal, Quebec
Contact: Sarah Markey,
Congress Manager, ICMS Pty Ltd,
84 Queensbridge Street,
Southbank, Victoria, Australia
tel 61 3 9682 0244
fax 61 3 9628 0288
web www.vanderbilt.edu/CINP/

T 2002: 16th International Conference on Alcohol, Drugs and Traffic Safety

August 4–9, Montreal, Quebec
Contact: Elizabeth Wells-Parker, ICADTS
Secretary, Mississippi State University,

Mississippi State, Mississippi 39762, USA
tel (601) 325-7959
fax (601) 325-7966.
e-mail bwparkers@ssrc.msstate.edu
web www.saaq.gouv.qc.ca/t2002/

52nd Annual Meeting of the Canadian Psychiatric Association

October 31–November 3,
Banff Springs, Alberta
Contact: CPA Head Office,
260-441 MacLaren Street,
Ottawa, ON K2P 2H3
tel (613) 234-2815
fax (613) 234-9857
e-mail agm@cpa-apc.org

UNITED STATES

American Society of Neuroimaging

March 7–10, Tampa Bay, Florida
Contact: Meeting Coordinator,
tel (952) 545-6291
web www.asn.org

Anxiety Disorders Association of America – 22nd National Conference

March 21–22, Austin, Texas
Contact: Meeting Coordinator,
tel (301) 231-9350
web www.adaa.org

American Association of Suicidology's 35th Annual Conference

April 10–13, Washington, DC
Contact: Amy Kulp,
tel (202) 237-2280
fax (202) 237-2282
e-mail info@suicidology.org

International Society of Psychiatric Mental Health Nurses – "Action, Advocacy, Adventures: The Politics and Progress of Psychiatric Mental Health Nursing"

April 24–27, Washington, DC
Contact: Professional Nursing
Resources, Inc.,
tel (717) 703-0036
e-mail aleta@pronursingresources.com
web www.ispn-psych.org/

American Psychiatric Association Annual Meeting

May 18–23, Philadelphia, Pennsylvania
Information: APA Office of International
Affairs, 1400 K Street NW,
Washington, DC 20005,
tel (202) 682-6000
fax (202) 682-6850
e-mail apa@psych.org.

American Psychological Society 14th Annual Convention

June 6–9, New Orleans, Louisiana

Contact: Meeting Coordinator,
tel (202) 783-2077
web www.psychologicalscience.org

10th World Congress on Pain

August 17–22, San Diego, California
Contact: International Association for
the Study of Pain, Secretariat,
909 NE 43rd Street, Suite 306,
Seattle, WA 98105
tel (206) 547-6409
fax (206) 547-1703
e-mail IASP@locke.hs.washington.edu
web www.halcyon.com/iasp/

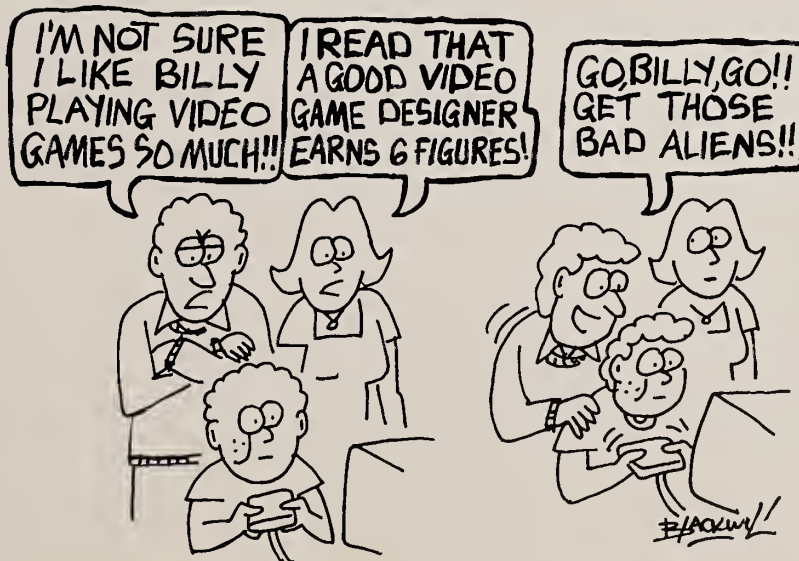
National Association of Rural Mental Health 28th Annual Conference – Riding the Winds of Change: Alternatives for the Journey

August 26–29, Sante Fe,
New Mexico
Contact: LuAn Rice,
tel (320) 202-1820

Treating Addictions in Special Populations: Research Confronts Reality

October 7–8, Binghamton, New York
Contact: Jane Angelone,
Conference Coordinator, Professional
Development & Research, Binghamton
University, PO Box 6000 (AB-130),
Binghamton, NY 13902-6000

Cont'd...



tel (607) 777-4447
fax (607) 777-6041
e-mail angelone@binghamton.edu
web sehd.binghamton.edu/
pdr/index.htm

American Psychiatric Association's Institute of Psychiatric Services

October 9–13, Chicago, Illinois
Contact: Meetings Management
Department, American Psychiatric
Association, 1400 K Street, NW,
Washington, DC 20005
tel (202) 682-6100
fax (202) 682-6114
e-mail apa@psych.orgweb
www.psych.org

American Psychiatric Association Annual Meeting

May 17–22, 2003, San Francisco,
California. Contact: APA Office of
International Affairs, 1400 K Street NW,
Washington, DC 20005
tel (202) 682-6000
fax (202) 682-6850
e-mail apa@psych.org

Institute on Psychiatric Services

October 29–November 2, 2003,
Boston, Massachusetts
Contact: APA Office of International
Affairs, 1400 K Street NW,
Washington, DC 20005
tel (202) 682-6000
fax (202) 682-6850
e-mail apa@psych.org

ABROAD

Cuban Pan-American Congress of Child and Adolescent Psychiatry

March 5–8, Havana, Cuba
Contact: Barbara Collins, 7845 Camino
Real, 0-412, Miami, FL 33143
tel (305) 596-7674
fax (305) 279-8665
e-mail BCol410293@aol.com

Infant Mental Health Course

April 2–5, Cape Town, South Africa
Contact: Mrs. Janet Sirmongpong,
tel 27 214 066 330
fax 27 214 486 263
e-mail jsirmong@curie.uct.ac.za

3rd International Conference on Drugs and Young People

May 13–15, Sydney,
New South Wales, Australia

Contact: Conference Secretariat,
fax 61 03 9328 3008
e-mail events@adf.org.au
web www.adf.org.au

5th Conference of the European Opiate Addiction Treatment Association: Evidence-based Practice & Integrated Treatment Approaches

May 14–16, Oslo, Norway
Contact: Egil Haga, Conference
Secretary, Unit for Addiction Medicine,
Kirkevn, 166, N-0407 Oslo
tel 47 23 01 60 50
fax 47 23 01 60 51e-mail
egil.haga@psykiatri.uio.no
web www.europad.org

24th European Conference on Psychosomatic Research

June 19–22, Lisbon, Portugal
Contact: Memotur, Travessa da Memoria,
51B 1300 – 402 Lisboa, Portugal
tel 351 1 364 40 97
fax 351 1 364 35 25
e-mail memotur@mail.telepac.pt

The International Institute of Forensic Studies, Inaugural Conference – "Expert Evidence: Causation, Proof and Presentation"

July 2–5, Prato, Tuscany, Italy
Contact: tel 61 3 990 54734
web www.law.monash.edu.au/iifs

18th World Congress of Psychotherapy

August 14–18, Trondheim, Norway
Contact: WCP-02, Department of Child
and Adolescent Psychiatry, Norwegian
University of Science and Technology,

30 MTF, No. 7489 Trondheim, Norway
tel 47 7386 7140
fax 47 7386 7166
e-mail wcp-02@medisin.ntnu.no

XVI European Conference on Philos- ophy of Medicine and Health Care

August 21–24, Qawra, Malta
Contact: Department of Ethics,
Philosophy and History of
Medicine, University Medical Center,
PO Box 9101, 6500 HB Nijmegen,
The Netherlands
tel 024 361 53 20
fax 31 24 3540254
e-mail h.tenhave@efg.kun.nl

XII World Congress of Psychiatry

August 24–29, Yokohama, Japan
Contact: XII World Congress of Psychiatry,
c/o Convention Linkage, Inc.,
Akasaka Nihon Bldg., 9-5-24 Akasaka
Minato-ku, Tokyo, Japan
tel 81 3 5770 5549
fax 81 3 5770 5532
e-mail wpa_sec@c-linkage.co.jp
web c-linkage.co.jp/WPA/

15th International Congress: The International Association for Child and Adolescent Psychiatry and Allied Professions

October 29–November 2, New Delhi, India
Contact: The Secretariat, Savita
Malhotra, Professor of Psychiatry,
Postgraduate Institute of Medical
Education and Research.
Chandigarh 160 012, India
tel 91 172 747 585 ext. 521
e-mail savita@ch1.dot.net.in
web www.childindia.org

World Federation for Mental Health Biennial Congress

February 23–28, 2003, Melbourne,
Victoria, Australia
Contact: Secretariat, ICMS Pty Ltd.,
84 Queensbridge Street, Southbank,
Victoria, Australia 3006
tel 61 3 9682 0244
fax 61 3 9682 0288
web www.icms.com.au/

16th International Hypnosis Congress

August 2–8, 2003, Singapore
Contact: Secretariat, ICMS Pty Ltd.,
84 Queensbridge Street, Southbank,
Victoria, Australia 3006
tel 61 3 9682 0244
fax 61 3 9682 0288
web www.icms.com.au/

VIII World Congress of Biological Psychiatry

September 28–October 3, 2003,
Buenos Aires, Argentina
Contact: WCBP 2003 Congress
Secretariat, Congresos Internacionales
S.A., Moreno 584, 9th Floor (1091),
Buenos Aires, Argentina
tel 54 11 4342 3216/3408
fax 54 11 4331 0223/4334 3811
e-mail conginte@congresosint.com.ar

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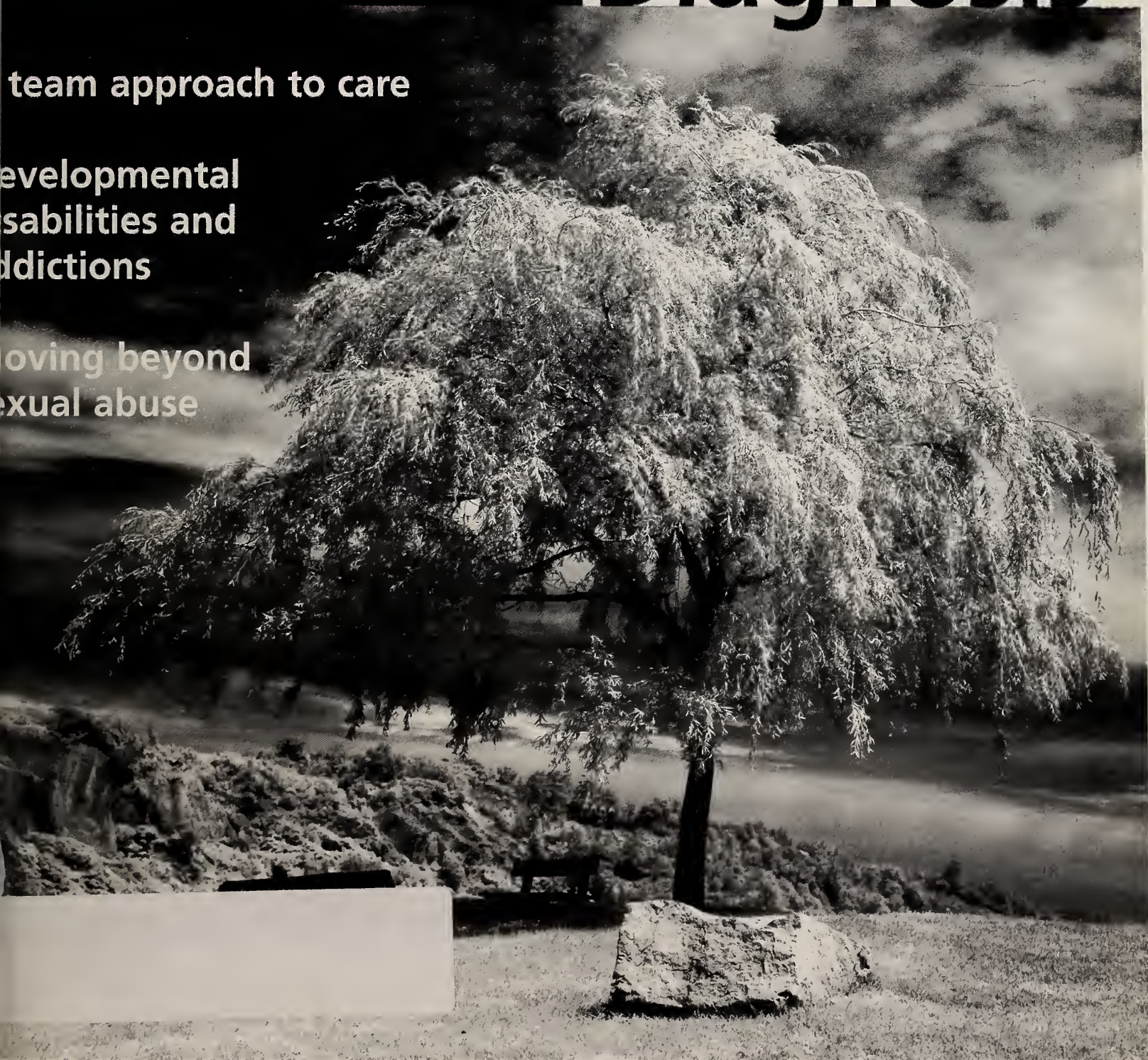
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Cover



Untitled, Rishi Vasudeva, black & white photograph

Rishi Vasudeva was born in Birmingham, England, where he studied photography at the Bournville School of Art. His photographs were recently exhibited at a charity art show in Toronto. His work is on display at CAMH's Clarke site.

News from the Centre

CAMH receives its second full accreditation

The Centre recently underwent its second successful accreditation since the merger in 1998. During the week of March 3–8, 2002, surveyors from the Canadian Council on Health Services Accreditation visited the Centre to review its clinical programs and services. As a result of months of hard work by numerous staff across CAMH, we are pleased to announce that we have received our second three-year accreditation with recommendations. The surveyors were very impressed by the Centre and how far we have come since the merger. As part of the accreditation debriefing, our surveyors commended the Centre's staff commitment to and enthusiasm for the accreditation survey process. They were particularly impressed by quality initiatives and felt that overall post-merger morale was quite good. Congratulations to all Centre staff who worked to make accreditation a success.

New CAMH product

Knowing that women who experience trauma often turn to front-line services for help, the Centre has recently published a book called *Bridging Responses: A Front-Line Worker's Guide to Supporting Women Who Have Post-Traumatic Stress*. The book is the first in a series of trauma literature that the Centre will be developing for professionals. It offers information and tools for responding to post-traumatic stress in women's lives and for encouraging women who have survived abuse and violence to consider referrals to appropriate services and resources. To order a copy, or for more information on other Centre resource materials, please contact Marketing and Sales Services at (800) 661-1111 or marketing@camh.net.

A CAMH first

On April 3, the Ontario Council on Alternative Businesses (OCAB) and the United Way, in partnership with CAMH, hosted a celebration of the transfer of ownership of the Out of this World Café from the Centre's vocational program to OCAB, which occurred in January. Centre management, community agency and alternative business representatives and staff and clients attended to acknowledge this significant and exciting moment in the Centre's history. This is the first time a CAMH vocational program has evolved into a full-fledged business that provides true employment opportunities for our clients.

CHRISTA HAANSTRA



"LET'S REVIEW THE PRIME CAUSES OF YOUR ANXIETY.
YOUR SON'S MARRIAGE...YOUR MOTHER'S HEALTH...
AND WINDOWS MILLENNIUM EDITION!"

Note from the Editor

People with co-occurring developmental disabilities and mental health issues – known as dual diagnosis – are among Canada's most disadvantaged and most disabled citizens.

Yet dual diagnosis has often been rendered invisible in the eyes of professionals and has frequently been treated ineffectively and inappropriately.

In this issue's focus section, we discuss both addiction and mental health problems among people with developmen-

tal disabilities and explore the issues that affect the provision of services and supports to these individuals. Collectively, the stories call for positive changes in those services and in the lives of the people involved.

Lisa Schmidt's story about a young man with autism and mental health issues illustrates the positive changes that can occur when multidisciplinary teams collaborate to address the complex issues involved in dual diagnosis. Tamsen Tillson and I discuss how, in the wake of deinstitutionalization and community integration of people with developmental disabilities, addiction may become a growing concern. Diana Ballon discusses the need to address women's mental health issues resulting from a history of abuse, whose prevalence has been estimated to be as high as 80 per cent among people with developmental disabilities.

Also in this issue is a story about how various drug education initiatives in Rio de Janeiro's poor neighbourhoods are empowering residents and reinforcing their sense of pride in these colourful communities. And, as Honey Fisher reports, groundbreaking research out of the University of California at Los Angeles indicates that positron emission tomography may facilitate early detection of Alzheimer's disease.

At this point I would like to thank you for your feedback in the readership survey that was sent out earlier this year. Based on your input, we will be making some changes over the next few issues that will help us to continue to provide you with the stories and information that you want. Beginning in the autumn, we will shift to quarterly publication and increase the number of pages per issue, which will allow us to delve more deeply into the issues that interest you.

We always welcome your input to the magazine. It is your feedback that helps us evolve. Let us know how we are doing. Or write a letter to the editor expressing your thoughts on our stories.

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In Brief

Youth mix sex with alcohol and other drugs



Young adults who use alcohol or other drugs are seven times more likely than non-drinkers to have sex, according to a survey conducted by the Kaiser Family Foundation. The survey of 1,200 13- to 24-year-olds found that 23 per cent of sexually active youths have unprotected sex when they have been drinking or using drugs. Overall, 29 per cent of 15- to 17-year-olds and 37 per cent of 18- to 24-year-olds said alcohol or other drugs influenced their decision to engage in sex. In addition, 29 per cent of 15- to 24-year-olds said they have "done more" sexually than they planned because they were drinking or using drugs. The findings point to the need for sex education that discusses the connection between sexual activity and alcohol and drug use.

Australian deaths force review of anti-psychotic drug

The treatment of almost 50 mental health clients in Queensland, Australia, is under review following the unexpected deaths of three clients taking clozapine, a drug used to treat schizophrenia and other psychotic conditions. *The Australian* reported that the three male clients, between 30 and 50 years old, had been taking clozapine for several years and had been living in the community. Queensland Health's director of mental health, Dr. Peggy Brown, said there were no proven links between the drug and the unexplained deaths, which are being investigated by the coroner.

AA revises Big Book

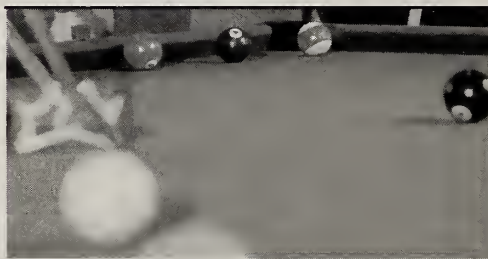
For just the third time in 62 years, Alcoholics Anonymous (AA) has revised its members' guide, known as the *Big Book*, to better reflect stories of individuals fighting alcohol addiction, reports the organization. While the *Big Book* outlines AA's philosophy, principles and

methods, it also contains personal testimonies of people recovering from alcohol addiction. The new edition has added 24 new stories to reflect the growing diversity of AA's membership. The additions were selected from more than 1,200 personal testimonies that were submitted by AA members throughout the United States and Canada.

Addiction problem growing in China

The number of people with drug addictions in China has jumped to 901,000 from 860,000 within a year, reports the Associated Press. Minister of Public Security Jia Chunwang links the increase to a rise in crime and AIDS. In a state media report, Jia said that people with addictions commit more than 30 per cent of all robberies in China to pay for drugs. In addition, two-thirds of new AIDS cases arise from sharing dirty needles among heroin users. While China has approximately 28,100 confirmed AIDS cases, experts say the figure is closer to 600,000. To address the drug problem, Jia said China would implement strict measures to fight drug crime and would co-operate with neighbouring Myanmar and Laos in seizing drugs and introducing crop substitution.

High rates of gambling problems among Ontario youth



Young Ontario adults have a high rate of gambling problems, according to a report entitled *Measuring Gambling and Problem Gambling in Ontario*, released by the Canadian Centre on Substance Abuse and the Responsible Gambling Council (Ontario). The report is one of the most detailed pictures ever produced of gambling behaviours in the province. Researchers found that five of every six Ontario adults had gambled in the year prior to the study. Of these, 3.8 per cent had gambling problems, a number that almost doubles to seven per cent among

people between 18 and 24 years old. The authors call for enhanced policies and programs aimed at preventing or reducing gambling problems in this age group.

Military to ask soldiers about mental illness



Canada's military has commissioned a groundbreaking mental health survey to determine how many of its soldiers are feeling stressed, according to the *Toronto Star*. The results will help the Department of National Defence to determine how many personnel are suffering from psychological illnesses ranging from depression to post-traumatic stress disorder (PTSD), and will also help the Canadian Armed Forces develop programs that meet the mental health needs of personnel. A study conducted by the Armed Forces revealed that Canada is less equipped than other countries to help personnel cope with traumatic overseas assignments. Statistics Canada will survey 13,000 Armed Forces personnel beginning in May.

Government plans to suicide-proof tailpipes

The federal government is considering making it mandatory that suicide-resistant tailpipes be installed on vehicles in a move to cut down on deaths from carbon monoxide poisoning. This move was recommended in a discussion paper released by Transport Canada. A screen would prevent the insertion of a hose into the tailpipe, while hidden venting would allow exhaust gas to escape under the vehicle if a hose or bag is taped to the outside lip. Exhaust gas poisoning is the fourth most frequently used method for committing suicide in Canada, averaging about eight per cent of suicides in the last decade. If the idea is adopted, Canada would be the first country to make such a suicide-resistant tailpipe mandatory.

HEMA ZBOGAR

Brain scans show promise in diagnosing Alzheimer's disease

SCIENTISTS AT THE UNIVERSITY OF CALIFORNIA AT LOS ANGELES (UCLA) are breaking new ground in the fight against Alzheimer's disease (AD). They conducted an imaging study, published in the February 2002 issue of the *American Journal of Geriatric Psychiatry*, using a new technique that, for the first time, detects the physical evidence of AD in the brains of living persons.

The UCLA scientists injected a chemical marker with a radioactive tracer into nine people with AD and seven healthy control volunteers. The chemical, known as FDDNP, bound to the AD patients' plaques and tangles, the brain lesions that are the definitive hallmarks of AD progression. By combining this chemical marker with positron emission tomography (PET), the researchers were able to visually locate the lesions in the brain. After one of the Alzheimer's patients died, a brain autopsy was performed, verifying both the location of the lesions indicated by the PET scan and the diagnosis of AD.

"This is potentially a very important study," says Dr. Gordon Winocur, a neuropsychologist and scientific director of the Alzheimer Society of Canada. "We've never had a reliable way of actually detecting the presence of plaques and tangles in the living brain."

AD is the most common form of dementia, accounting for approximately two-thirds of all dementias. However, no single test in living persons currently exists that distinguishes AD from other dementias. The diagnosis is made through clinical assessment to rule out other possible causes of dementia. Usually, significant deterioration has already occurred by the time AD is diagnosed. It is not until after the person has died and a brain autopsy is performed that a definitive diagnosis can be made. According to Dr. Jorge Barrio, principal investigator of the UCLA study, current diagnostic tests are not precise and can have a degree of accuracy as low as 55 per cent compared with autopsy results.

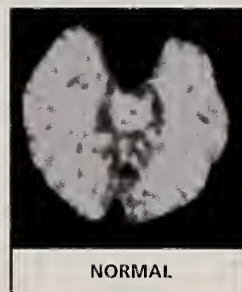
"In conjunction with neuropsychological assessment, it's a much more reliable diagnosis," says Winocur. "If this pushes back the period of detection to the very early stages, then treatment can be started earlier, with much better prospects of success."

The cutting-edge technique would help people with AD prepare for the debilitating effects of AD. "We know that amyloid plaques and tangles accumulate decades before people actually get the disease," says Dr. Gary Small, a professor of aging at UCLA and co-author of the study.

At present, these types of PET scans are expensive and used primarily for experimental purposes. Eventually, they may become a general diagnostic tool. Dr. William Klunk, a geriatric psychiatrist at the University of Pittsburgh, hails this study as an important milestone in the field. "This is a forward-looking technique for when we begin to do human trials with drugs under development that are designed to either prevent plaques and tangles from forming or reverse existing deposition," says Klunk.

"It's very expensive to do drug trials," says Small. "If we have a way to monitor the treatment in a few patients, that's going to move the field forward quickly and save time and money."

Drugs currently under development tend to target either plaques or tangles, but not both. So, the UCLA team plan to develop probes with specificity. But, according to Small, "there is also an advantage of having



NORMAL



ALZHEIMER'S DISEASE

A PET scan shows the plaques and tangles, characteristic of Alzheimer Disease, that are not present in a healthy brain.

Credit: J.R. Barrio et al, UCLA School of Medicine

a non-specific marker in that it gives you an idea of overall burden, which may be one reason there is such a strong correlation between the signal and the person's cognitive performance."

"My main concern with this technique," says Klunk, "is that it is a relatively non-specific and insensitive way of imaging plaques and tangles. An ideal imaging probe sticks to its target and nothing else. The problem is that FDDNP binds to plaques and tangles as well as other lipophilic structures in the brain. But it's a start."

HONEY R. FISHER

Public Information & Education RESOURCES

The Centre for Addiction and Mental Health, a World Health Organization Centre of Excellence, is committed to making available resources that provide better understanding, prevention and care in the fields of mental health and addiction.

Reflecting the best practices of one of the world's most respected addiction and mental health research hospitals, these valuable publications will support the delivery of any public education mandate.

Our information booklets, brochures and pamphlets include, among others, a "road rage" test, guidelines for low-risk drinking, general information about trauma and

its effects, fact sheets about addictive substances, a booklet to help women identify the effects of trauma in their lives, and a number of mental health promotion resources for immigrants new to Canada.

To receive a catalogue of these resources, or for more information, please contact:

Marketing and Sales Services
Centre for Addiction and Mental Health
1 800 661-1111 or 416 595-6059 in Toronto
marketing@camh.net



Centre
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Centre de
toxicomanie et
de santé mentale

Limited quantities of these resources are free to Ontario residents.

Health care policies discriminate against people with mental illness

IMAGINE HAVING A PSYCHIATRIC DISORDER AND BEING DENIED comprehensive insurance coverage because your problem is mental, not physical. Unfortunately, this kind of bias is common in North America.

Last year, the National Mental Health Association (NMHA), the largest U.S. non-profit organization working for the rights of psychiatric clients, saw a parity bill go down to narrow defeat in Congress. Parity legislation would have required companies with more than 50 employees that offer health insurance to their employees to extend benefits to cover psychiatric problems. "Offering widely varying benefits amounts to invidious discrimination against people with mental illness," says Ralph Ibson, vice-president of government affairs for the NMHA.

The parity bill was opposed by insurance companies and lobby groups such as the ERISA Industry Committee (ERIC). ERISA stands for "Employee Retirement Income Security Act," a piece of federal legislation that regulates pensions and other employer benefits. ERIC describes itself as "an association of America's largest employers committed to the advancement . . . of [voluntary] employee benefit plans" that supports "market-based health care reform" over government-mandated initiatives.

ERIC feared the bill would put an undue financial burden on employers and give the federal government too much control over company-based health insurance policies. "By mandating that employers cover mental health services the same way they cover other medical and surgical services, Congress will open the floodgates to over-utilization and explosive mental health claims costs," warned ERIC president Mark Ugoretz in a statement released in late 2001.

While over 30 states have already passed parity laws, these statutes don't affect large corporations in the United States, where federal and state health regulators have different responsibilities. Big businesses are generally subject to federal health insurance laws, while small businesses are covered by state legislation.

While seniors and the poor are eligible for government programs, working people must usually rely on private insurance policies, which are often provided by employers. "In New York state, about 90 per cent of people who have private health insurance get their insurance through their place of employment," explains Joseph Glazer, president and CEO of the Mental Health Association in New York state. Of those New Yorkers who get it through their work-place, "about 90 per cent are in what are known as 'managed care plans,'" says Glazer.

These plans are run by Health Maintenance Organizations (HMOs), which offer lists of health care providers clients can go to and services and medications they can use. People with physical problems are often allowed unlimited visits to health care providers. But this isn't the case for mental illness. In New York state, private insurance policies might limit a patient to 20 outpatient and 30 inpatient mental health visits per year, says Glazer.

People with physical conditions are charged a co-payment of around \$10 for each visit. But clients with psychiatric problems often face sharply increasing co-payments on successive visits.

Opponents of the legislation point to differences in the way people use mental health services versus other health services. "If consumption patterns are different between physical and other mental health services, then cost-sharing should be different," says Anthony Knettel, vice-president of health affairs for ERIC.

Parity is also an issue in Canada. People who disclose mental illness are turned down for life insurance. Adequate funding for mental health is another concern. While one in four Canadians experience mental illness at some point in their lives, mental health funding constitutes less than 10 per cent of provincial and national health spending. "Mental health funding has become an issue, as the envelope tends to bleed into funding for physical health care, as government and health authorities respond to clogged emergency rooms and other issues," says Steve Lurie, executive director of the Canadian Mental Health Association, Toronto branch.

In February, a commission headed by former Saskatchewan premier Roy Romanow released an interim report on the future of Canada's medical system. "The report doesn't have a lot about mental health in it," says Dr. Carolyn Dewa, a health economist at the Centre for Addiction and Mental Health. "Mental health is often ignored, swept aside as an issue to be wrestled with after physical health has been dealt with."

Ironically, as Canada flirts with private health care, the United States is moving toward greater government control of the medical system. Parity legislation has already been reintroduced in Congress, and this time, supporters think it will pass. Psychiatric fallout from the events of September 11 is believed to be the reason why. "U.S. citizens suffering from post-traumatic stress disorder will find themselves bumping up against the artificial limits of their health insurance policies," states Glazer. He adds that as this starts happening, it will become "very, very hard to deny that parity has to go through, even in Congress."

NATE HENDLEY

Women and Trauma Series

Current literature in the field of women's health suggests that many of the problems women face arise from chronic childhood abuse or neglect. CAMH is producing a series of publications offering practical tools for women, therapists and front-line workers.

- *Trauma: Common Questions* is a brochure for the general public that answers common questions about trauma.
- *Women: What do these signs have in common?* is a booklet for women who might have experienced abuse-related trauma.
- *Bridging Responses* is a booklet to help front-line workers recognize responses to complex PTSD in women's lives.
- *First-Stage Trauma Treatment* is a practical guide for therapists on first-stage trauma treatment.

To receive more information about these resources, please contact Marketing and Sales Services:

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Trauma therapy and community action help mothers of street violence victims



IN APRIL 2000, DAWN DRUMMOND'S 13-YEAR-OLD SON* WAS walking to a basketball game in a Toronto suburb, when a gunman began randomly shooting from a car. Pedestrians rushed for cover, but Drummond's son accidentally stepped into the line of fire. He was shot in the head and lost an eye – the victim of a senseless act of violence.

Two years later, Drummond recalls her reaction when she heard the news. "You don't feel, because you die," she recalls. "You are in such shock that your whole body goes dead. I remember sitting in the hospital after the shooting," she continues. "I had lots of friends and family. And I remember saying to myself, 'I'm standing in the middle of all these people but I'm alone ... I'm dying inside.'"

Following the shooting, Drummond, who works as a telephone operator, became involved in two initiatives that have helped her come to terms with the act of violence. She helped launch a group called United Mothers Opposing Violence Everywhere (UMOVE), a Toronto-based organization largely made up of mothers of slain victims. And she and her son began seeing Teresa Marsh, a private therapist who counsels trauma victims, and manager of the Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY) at the Centre for Addiction and Mental Health.

Marsh describes trauma as a natural consequence of witnessing or experiencing a horrific event, which can include war, violence, childhood abuse, sexual assault and torture. Trauma isn't an experience that victims can easily recover from.

Some trauma victims, such as Drummond, become apathetic and experience feelings of "deadness." Others become aggressive and angry. If this anger is directed internally, it can lead to self-harm, substance use problems and suicide. If it is directed externally, outbursts of violence and rage can result, explains Marsh.

Trauma can also cause alterations in self-perception. Victims often feel worthless and become depressed, making it harder to hold down a job and manage a home. These factors in turn can drive a person to criminal behaviour to survive.

While it is devastating for individuals, trauma also has grievous societal implications. "Without therapeutic intervention, traumatized people often end up as burdens of the legal, health care and welfare systems, and threats to public safety," says Marsh.

Given these risks, counsellors who deal with trauma victims need to take special care to build trusting relationships with clients. The main elements of therapist/client trust include "acceptance, deep listening, love, compassion and caring," according to Marsh.

To establish trust with the Drummond family, Marsh travelled to their home for the first session. Drummond was deeply touched by this gesture and says the initial meeting, which took place last summer, "felt very comfortable." Subsequent visits, usually conducted at Marsh's office, have

proven highly beneficial for both mother and son, reports Drummond.

In addition to building trust, it is important for therapists to teach trauma victims the benefits of self-care – methods that clients can use to calm themselves in moments of anxiety. "Such techniques can be extremely helpful as clients come to acknowledge the depth of their trauma and look for ways to express their feelings," explains Marsh.

Counsellors need to ensure that a client enjoys a strong support network of friends and family. Marsh says that such networks are important because therapy often "opens up the whole gamut of flashbacks, bad dreams, self-defeating behaviour and other problems."

Drummond, for example, has derived a huge amount of support from UMOVE. "Every mother in UMOVE knew the kind of pain I was going through," recalls Drummond of her first encounters with the group. "It was such a relief to know I could talk about how I felt, and people could identify with me."

In addition to providing emotional support, UMOVE has a political agenda. Following a spate of murders among young black men in Toronto, the group organized a peace vigil at Nathan Phillips Square in the fall of 2001. The organization hopes to get involved in community awareness meetings, such as seminars in schools, says UMOVE'S current chair, Audette Shephard.

In the meantime, Drummond urges trauma victims to seek help. "There is no way you can overcome such pain by yourself ... you need to let it out, need to talk about, verbalize it. You cannot do it by yourself."

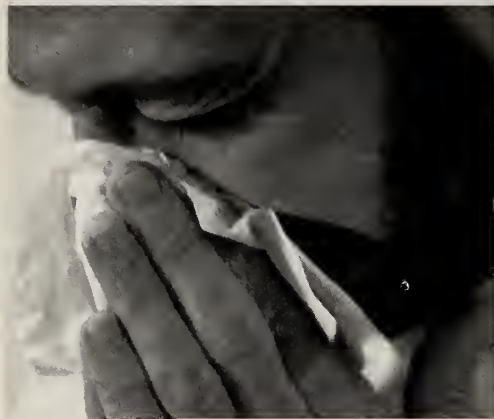
*name withheld

NATE HENDLEY

For more information, please contact Audette Shephard, UMOVE chair, 545 Sherbourne Street, Suite #2001, Toronto, ON M4X 1W5 telephone: (416) 922-1783.

Research Update

Alcohol may increase susceptibility to allergies



Alcohol consumption, even at moderate levels, has an effect on the body's immune system that could make people more susceptible to allergies. Spanish scientists monitored levels of immunoglobulin E (IgE, the main immunoglobulin involved in allergic diseases) in the blood of 260 consumers of moderate amounts of alcohol (median of 30 grams of alcohol per week) and 200 abstainers. Some participants had existing allergies. The researchers found that levels of IgE were higher in alcohol consumers than in abstainers and increased as levels of consumption increased. Among participants allergic to house-dust mites, concentrations of IgE specific to those mites were higher in alcohol consumers than in abstainers.

Previous studies have shown increases in IgE among people with alcohol dependency, but this is the first study to show a similar effect among moderate consumers of alcohol. While the mechanisms of alcohol's effect on IgE levels are not known, the authors suggest they may be related to B-cell depletion or changes in cytokine balance. The authors indicate that it is still unclear whether increased levels of IgE lead to more allergic symptoms or increased susceptibility to allergies.

Alcoholism: Clinical and Experimental Research, January 2002v. 26 (1): 59-64. C. Vidal, Department of Allergy, Complejo Hospitalario Universitario de Santiago, Santiago, Spain.

Methadone may pose risk for HIV-infected clients

New research from the Children's Hospital of Philadelphia in Pennsylvania indicates that methadone increases the infectivity of HIV in laboratory cultures of human blood cells and brain tissue. Researchers found that the addition of methadone to cultures of peripheral blood mononuclear cells taken from HIV-infected clients increased rates of viral activation and replication. The researchers speculate that this effect may result from activation of the HIV long-terminal repeat (LTR) promoter. In cultures of human fetal microglia (a type of brain tissue) and blood monocyte-derived macrophages (MDMs), the presence of methadone significantly increased infection rates when the cultures were exposed to HIV. The effect on MDMs may be due to a decrease in beta-chemokine production and an increase in the activity of the CCR5 receptor on the MDMs, in addition to LTR activation.

These results raise concerns about the use of methadone to treat opiate dependency among HIV-infected clients. However, since there is no clear evidence of such a negative effect among clients receiving methadone treatment, the authors indicate that further study is needed to determine the effect of methadone on HIV infection and AIDS.

The Journal of Infectious Diseases, January 1, 2002, v. 185: 118-122. Yuan Li et al, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania.

Smoking during pregnancy increases child's risk of diabetes

Children of women who smoke during pregnancy are more likely to develop diabetes later in life. Researchers at the Karolinska Institute in Stockholm, Sweden, arrived at this finding using data from the British National Child Development Study. Of the 11,359 individuals they followed, 28 developed type 2 diabetes between the ages of 16 and 33. Compared to the children of mothers who did not smoke during pregnancy, those whose mothers were heavy smokers (more than 10 cigarettes a day) during pregnancy were more than four times as likely

to develop diabetes. The risk for children of medium smokers (less than 10 cigarettes a day) was marginally increased, but this result was based on only three cases of diabetes. Obesity, a significant risk factor for diabetes, was 34 per cent and 38 per cent more common among the children of medium and heavy smokers, respectively. Individuals who smoked 30 or more cigarettes per week at age 16 increased their risk of diabetes by as much as 3.6 times. The authors speculate that maternal smoking may cause fetal malnutrition or toxicity, resulting in lifelong dysregulation of the child's metabolism.

British Medical Journal, January 5, 2002, v. 324 (7328): 26-27. Scott M. Montgomery and Anders Ekborn, Epidemiology Clinic, Karolinska Institute, Stockholm, Sweden.

Child abuse may trigger schizophrenia



Adults diagnosed with schizophrenia may have developed the disorder as a result of child abuse. A group of researchers from New Zealand and Canada point to numerous studies that show high rates of child sexual and physical abuse among adults diagnosed with schizophrenia or other psychotic disorders. They also note that abuse victims and people with schizophrenia exhibit similar abnormalities in brain structure and biochemistry, which include over-reactivity of the hypothalamic-pituitary-adrenal axis, damage to the hippocampus, cerebral atrophy, ventricular enlargement, reversed cerebral asymmetry, increased dopamine activity and

decreased serotonin activity. Severe or persistent traumatic events during childhood can lead to such abnormalities either through hyper-arousal ("fight-or-flight" response) or dissociation ("freeze" or "surrender" response).

However, the researchers note that most abuse victims do not develop schizophrenia, and not all people with schizophrenia were abused as children. The researchers suggest that the severity of abuse may partly determine who develops schizophrenia. They urge that the fear of being accused of "family-blaming" should not deter research into the role of child abuse in schizophrenia. The researchers also see an urgent need for effective treatment for survivors of abuse diagnosed with schizophrenia.

Psychiatry, Winter 2001, v. 64 (4): 319-337. John Read et al, Psychology Department, University of Auckland, Auckland, New Zealand.

Shared family activities promote mental health among youth



Well-adjusted adolescents and young people share more activities with their families than do those with mental health problems. Spanish researchers studied 259 individuals aged 14 to 23 who lived with their families in the Spanish city of Alicante. Eighty-two of these youths were seeking treatment for mental health problems, such as anxiety and depression, while the remainder were control participants drawn from area schools. The researchers found that those with mental health problems shared meals with their parents an average of 4.5 times a week, compared to six meals a week for controls. Those with mental health problems also got together with their families less often for

special events, such as New Year's Day or farewell parties, and shared in fewer family activities, such as travel, conversations or help with school work. Individuals with mental health problems were twice as likely to perceive some dysfunction in their families and three times as likely to perceive severe family dysfunction.

The study highlights the importance of family rituals that promote communication and emotional closeness. The authors conclude that the lack of such rituals impairs social skills and self-esteem, and "impedes the resolution of the crisis of adolescence."

Journal of Epidemiology and Community Health, February 2002, v. 56 (2): 89-94. Elena Compañ et al, Health and Social Services of Alicante District, Alicante, Spain.

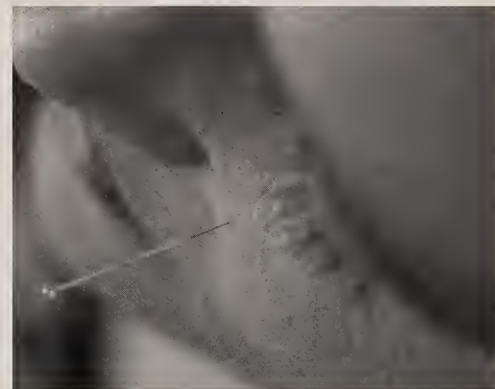
Bipolar and panic disorders may share genetic origin

There may be a genetic link between bipolar disorder and panic disorder in families where bipolar disorder is common. Researchers at Johns Hopkins University, in Baltimore, Maryland, studied 203 families in which at least one member had bipolar disorder. Among individuals with either bipolar disorder or recurrent unipolar depression, having a relative with both bipolar disorder and a history of panic attacks increased the risk of panic disorder by 75 per cent. Individuals with bipolar disorder were 55 per cent more likely than those with unipolar depression to have panic disorder. However, the presence of both bipolar disorder and panic disorder in one family member did not mean that other members of that family with bipolar disorder also had panic disorder.

These findings suggest that the role of genetics in these disorders is complex. The researchers suggest that variable expression of a single gene may produce the combination of bipolar disorder and panic disorder in some individuals, but not in others. Alternatively, they suggest that these disorders may be the result of a combination of genes, or the occurrence of panic may be triggered in some people by manic or depressive symptoms of bipolar disorder.

American Journal of Psychiatry, January 2002, v. 159 (1): 30-35. Dean F. MacKinnon et al, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Acupuncture ineffective treatment for cocaine addiction



Although acupuncture is often used to treat cocaine addiction, a new study indicates that such treatment has no discernible benefit. American scientists recruited 412 cocaine-dependent clients from three hospital-affiliated clinics, and 208 methadone-maintained clients who used both opiates and cocaine. Approximately one third were given auricular acupuncture according to guidelines approved by the National Acupuncture Detoxification Association (NADA). One control group received acupuncture with needles inserted at points not approved by NADA, while a second control group viewed a relaxation video. Methadone-maintained clients also continued to receive methadone.

Cocaine use declined for all three groups by the end of the eight-week treatment and at a six-month follow-up, but there were no significant differences in cocaine use among the groups. There were also no significant differences on measures of addiction-related problems; for example, employment, family, legal and psychiatric issues. The authors conclude that acupuncture is not effective as a stand-alone treatment for cocaine addiction, although it may contribute in an ancillary role.

Journal of the American Medical Association, January 2, 2002, v. 287 (1): 55-63. Arthur Margolin et al, Yale University School of Medicine, New Haven, Connecticut.

MARK DE LA HEY

Drug education programs improve awareness in Brazil's poor neighbourhoods

MIDO DOS SANTOS CLIMBS THE STEPS, higher and higher into the *favela* or hillside neighbourhood he calls home. Perched above the swank Rio district of Leme, Chapeu Mangueira is one of about 600 *favelas* in this Brazilian city of more than 10 million people.

Dos Santos guides tourists through his *favela*, which houses some of Rio's poorest residents. He delights in introducing visitors to the sense of community that exists in Chapeu Mangueira. "I want people to see what life is like in my *favela*," says dos Santos. He takes his visitors into the maze of narrow walkways lined with small cement and clapboard houses. The group strolls past children at play in a community schoolyard, past two ragtag dogs tussling over some food scraps. Nearby, construction workers chip away at a crumbling staircase that a *favela* revitalization program is restoring.

Climbing higher, the party encounters a group of patrolling military police, their expressions stern, their guns ready for action. "They're looking for drugs," says dos Santos, explaining that drug trafficking is a thriving business in Rio. Marijuana, cocaine and heroin are the drugs of choice.

The police are frequent visitors to Rio's *favelas*. But the glares directed at them by residents make it clear that these officers and their weapons are not welcome in the community.

A different approach to the drug problem

Meanwhile, in *favelas* throughout Rio, other anti-drug efforts are underway. Two World Health Organization (WHO) programs are addressing drug use and its accompanying problems in a unique way.

In Rocinha, Rio's largest *favela*, one project is reaching out to injection drug users to help them reduce their risk of HIV infection. The project, launched in 1997, enlists drug users to reach out to other drug users with harm reduction messages about safe injection procedures. These helpers distribute condoms and clean needles to drug users and distribute brochures and posters about the importance of using sterile needles when injecting. They are offered medical check-ups and receive a small stipend for their efforts.

"It's not a needle exchange," explains Dr. Andrew Hamid, a professor of social medicine at Columbia University in New York and one



Photo: Julia Drake



Chapeu Mangueira is one *favela* being revitalized with the introduction of community centres and better child-care assistance and drug awareness programs.

of the key researchers behind the project. "With needle distribution projects, researchers don't always know if the needles are being used or merely hoarded, so a needle exchange is something we'd like," he adds.

The existing program is enjoying some success. "We wanted to see if a simple drug education program would have any result on health," says Hamid. About two years into the project, researchers surveyed drug users in the *favela* and found that knowledge and awareness had improved.

However, as awareness doesn't always translate into behavioural change, the researchers sought further measures of success. This success was confirmed by statistics, gathered at the community's main medical clinic, which showed that the incidence of sexually transmitted diseases (STDs) had decreased. "People might say they're using condoms, but at the clinic we actually saw a reduction in STDs," says Hamid. "This project is evidence that a simple and targeted drug education initiative can bring about changes in people's level of awareness," says Hamid. "For a small project with a little bit of funding, the results are modest, but promising," he adds.

Further promise was seen in another project run by WHO along with the United Nations Children's Fund (UNICEF) for drug-using women and their children. Located at a child and maternal clinic in the same *favela*, the

project tests children for HIV and various neurological and organic problems. For mothers, the project provides medical check-ups, along with ongoing advice for improving their health and that of their children.

"It was part of a bigger project that looks at childcare and getting women back into the workforce – providing assistance for sustainable health," explains Hamid.

Since it was launched in 1999, the project has seen some positive results. "One of the most wonderful things about the project is that the women feel supported and encouraged," says Hamid. "There is a sense of hope. The women can feel what it's like to produce and raise a healthy baby. Through that, they feel a sense of hope for themselves."

While the project started with the assistance of WHO and UNICEF, it has now shifted to local ownership. And, like the needle and condom distribution project, it has had community involvement from day one. "The people who work on these projects are highly committed and proud of what they're doing," stresses Hamid, who remains involved as an adviser to both projects.

It is pride that dos Santos exudes when he leads tourists through his *favela*. As the government-funded revitalization continues to improve the *favela*'s infrastructure, that pride seems to continue to grow.

JULIA DRAKE

A team approach to care

Meeting the challenges of dual diagnosis

BY LISA SCHMIDT

CRAIG MOHLER IS AN ATHLETIC, AFFECTIONATE AND artistic 22-year-old man. He loves swimming, music and drama. And given how much he likes putting his arms around others, his father John describes him as a “hugaholic.”

While some aspects of Craig's life are those of a typical young man – attending school, taking walks on the beach and going on weekend hiking trips – the fact that Craig is blind and has autism and bipolar disorder means that his life is anything but typical.

Eden Cantkier, a program manager at Kerry's Place Autism Services in Toronto, has known Craig for many years. Kerry's Place is one of the partners in Craig's care plan and operates the house where Craig lives. Craig came to Kerry's Place following a period of hospitalization, precipitated by an increase in aggressive behaviour and other symptoms.

support, while reducing the likelihood that Craig would require further hospitalization.

“Given there are only so many psychiatric beds allocated to clients with a dual diagnosis, we have to provide services in the community that are supported by mental health programs,” says Susan Morris, clinical director of the Dual Diagnosis Program at the Centre for Addiction and Mental Health (CAMH). “Even though Craig no longer requires acute care, his team benefits from having access to CAMH's Dual Diagnosis Resource Service, which enhances the ability of caregivers to respond to those in their care.”

While many challenges are inherent in the care of people with a dual diagnosis, Morris says that solving a problem for clients can be made easier by gathering objective information



Craig with his mother, Anne Marie

What is autism?

Autism is a pervasive developmental disorder that typically appears by age three. The result of a neurological disorder that affects brain functioning, autism is estimated to occur in as many as one in 500 individuals, and is four times more prevalent in boys than girls. People with autism typically have difficulty with communication, social interaction and leisure activities. Aggressive or self-injurious behaviour may occur, as may repeated body movements, unusual responses to people or attachments to objects and resistance to change.

Source: Autism Society of America

“When we first met Craig, he was just over 17 and coming out of a low point in his life,” recalls Cantkier. He had been living with his parents and enjoying a relatively stable life. But as his behaviours worsened, he stayed briefly at the Griffin Community Support Network, where his agitation increased. He was then hospitalized at the former Queen Street Mental Health Centre, where his medication was reviewed and successfully changed. “Our goal following his discharge,” explains Cantkier, “was to recreate the stability he had at home – we had to do things differently to not precipitate another crisis.”

To this end, Kerry's Place created a team of care providers to attend to Craig in a house where he would initially live alone. The team received intensive training, including sessions taught by Craig's parents, John and Anne Marie, who had been his primary care givers. “Moving Craig into Kerry's Place was a turning point for him,” says John. “But it didn't come without a lot of work by Anne Marie, myself and many others.”

As they watched Craig's behaviour at home begin to deteriorate, the Mohlers took matters into their own hands. “Since Craig's autism is non-verbal, he was unable to articulate the severity of his symptoms,” says John. “We had little idea if his problems were caused by his autism, his mental health diagnosis or another medical condition.”

The Mohlers called a meeting of more than two dozen people to assess Craig's options. “His GP, members of community agencies, politicians, hospital staff, family, friends – you name it – we invited them to help,” recalls John. The group devised a care plan, a key component of which was access to psychiatric

for those, like Craig, who may be unable to articulate their needs. For instance, blood tests to monitor medication levels are useful, as is noting the quality and quantity of sleep.

“What serves us best is not making assumptions about why a certain behaviour is occurring,” says Morris. She gives the example of an inpatient with a similar diagnosis to Craig's who began to repeatedly bang his head against a wall. “We could have assumed this to be a worsening of his psychiatric symptoms, but experience told us it could be far simpler than that. And it was: a routine check by the GP turned up an ear infection. With antibiotics, the head-banging stopped.”

People with autism tend to do better with familiar environments and regular routines and may become distressed by change. Cantkier and Morris emphasize the importance of looking beyond the person to what's going on in their lives to determine whether the presenting behaviours are a normal reaction to a change in circumstances or whether they indicate a mental health problem. “This is why a multidisciplinary approach that includes family or significant others works best,” says Morris. “Someone on the team always sees a situation from a perspective others on the team aren't aware of.”

The approach seems to be successful. “Now that Craig has an independent life and has regular activities and familiar people around him, he's a pretty happy guy,” says John. “His skills have also developed. If there are any doubts that family and community involvement, coupled with access to medical and psychiatric care, were the needed ingredients in creating a successful life for kids like my son, I hope Craig's story dispels them.” ■

Developmental disabilities and addictions

Awareness emerges of an overlooked problem

BY TAMSEN TILLSON AND HEMA ZBOGAR

HEATHER*, A WOMAN WITH A DEVELOPMENTAL disability, asked her therapist to help her overcome her addiction to alcohol. Although therapist Cheryl Bedard is not trained in addiction treatment, she agreed to seek help for Heather.

And so began her search. Bedard, who works at Surrey Place Centre, a Toronto-based agency for people with developmental disabilities, called the larger agencies, she called the smaller agencies and hospitals, anyone she could think of. But the standard reply was that staff wasn't qualified to work with people with developmental disabilities. Finally, Bedard found the Dual Diagnosis Program at the Centre for Addiction and Mental Health in Toronto, which was willing to take Heather, provided that Bedard come along as an advocate and facilitator. "But by that time," Bedard recalls, "Heather was no longer interested."

But while overall addiction prevalence rates may be low, research and anecdotal evidence indicate that addiction may be a growing phenomenon among people with mild and moderate developmental disabilities, observes Dr. Kevin Brady, director of Habilitative Mental Health Care in Winona, Minnesota, in a 1993 *National Association for the Dually Diagnosed (NADD) Newsletter*.

Ironically, as deinstitutionalization and community integration increase among this population, so too do concerns about substance use problems. Dwindling financial support can lead to abysmal living conditions and isolation. Some individuals end up in boarding houses or even homeless, increasing their chances of being exposed to alcohol and other drugs. Those who turn to substances tend to use alcohol because it's cheap and easily available, but others turn to street

Research and anecdotal evidence indicate that addiction may be a growing phenomenon among people with mild and moderate developmental disabilities.



Little is known about addiction among people with developmental disabilities. Little research exists and there are virtually no treatment programs. Even working models for treating this population and training those who want to specialize in the area are scarce.

Clinical experience and what little research does exist indicate that the prevalence of addiction among people with developmental disabilities is lower than or equal to that in the general population. Dr. Louisa Degenhardt, a lecturer at the National Drug and Alcohol Research Centre at the University of New South Wales in Australia, suggests that cognitive deficits may partly explain this low rate of addiction. People whose disabilities are severe and profound have little independence and little awareness of, much less access to, alcohol or other drugs.

Individuals with developmental disabilities living in the community live in a range of environments, from sheltered group homes to apartments where they receive some support on a weekly basis. In these more supportive environments, individuals may never be exposed to addictive substances. Bedard points out that even when people with developmental disabilities do live independently, many lack the resources to finance an addiction. One of her clients heads out for a binge every month when her social assistance cheque arrives.

drugs such as crack cocaine. "Some become engaged in some pretty harmful drug use because the drugs are available to them," notes Bedard, recalling one client whose "friends" with addictions moved into her apartment and stole her money and possessions.

Brady notes that people with mild developmental disabilities may feel a strong need to fit in and may be more vulnerable to social pressures in an environment where alcohol or drugs are available. The neighbourhood bar may provide a sense of social acceptance and integration. But people with developmental disabilities who do use alcohol may be more vulnerable to developing a problem because cognitive impairment may reduce their ability to appreciate the consequences of their behaviour.

When these individuals do become addicted, the effects may be more devastating than among people without disabilities. In an article published in the *Journal of Intellectual and Developmental Disabilities* in 2000, Degenhardt notes that although alcohol use among people with developmental disabilities is lower than in the general population, the rate of problems is higher among drinkers with a developmental disability. "They may already have problems with everyday life – taking care of themselves, having friends and working,"



Individuals with developmental disabilities and addiction problems may face various obstacles in traditional addiction treatment programs:

- Treatment is too rapidly paced.
- Counsellors may be overly sympathetic toward these clients and not confront them when appropriate.
- Clients' concrete thinking and their lack of knowledge about substance abuse may be interpreted by therapists as denial.
- No validated standard model for treatment exists in this population.

Source: Thomas Bellows, *Recovery House: Residential Facility for Persons with Mild Mental Retardation and Substance Dependence* [PhD dissertation], 1996.

says Degenhardt. "When you have drug problems, daily living skills suffer. So a lower level of substance use may cause greater impairment to functioning than among people without developmental disabilities." In fact, combining substances like alcohol with medication, for example, anticonvulsants, may be life threatening.

Addictions tend not to be difficult to diagnose among people with developmental disabilities, says Degenhardt. "These individuals are often less able to hold themselves together," she explains. "The greater issue is what to do about the addiction once it is identified."

Because of a lack of specific services, many people with both a developmental disability and an addiction are referred to generic addiction services. However, such services may be ineffective and inappropriate. Addiction treatment is often based on a group model – a modality that can be difficult for people with learning disabilities, communication and cognitive deficits and poor social skills.

In a 1998 article in *Mental Health Aspects of Developmental Disabilities*, Dr. Dan Tomasulo, a psychologist and group psychotherapist in New Jersey, argues that "the combination of cognitive limitations, developmental delay and psychiatric involvement create a need for a different approach to treatment." Group approaches may be successful if they are modified to meet the needs of the client with a developmental disability.

"You could probably apply the cognitive strategies used in the generic addiction services," says Dr. Elspeth Bradley, a specialist in developmental disability psychiatry and psychiatrist-in-chief at Surrey Place. "But these strategies would have to be individ-

ually adapted to the cognitive and communicative abilities of the client, and treatment is likely to take longer compared to clients without disabilities.

Finding appropriate treatment is a challenge because there is already a chronic and long-standing shortage of more fundamental services. "When you look at people working in the field of developmental disability, they usually have their hands full with just treating behavioural problems," says Tomasulo. Not only are services lacking, but few professionals are trained to deal with both addiction problems and developmental disabilities.

Given the complex needs of individuals with developmental disabilities and addiction issues, effective treatment requires a comprehensive, integrated approach that includes both addiction and developmental disability specialists in a co-ordinated service using adapted treatment methodologies.

Addressing the addiction problem may require modifications to services traditionally provided to clients without developmental disabilities. Modifications may include more intense and individualized support, more structure, more concrete approaches and extended length of treatment and repetition of concepts. Support workers need to be prepared to work at a slower pace and must accept that understanding, insight, and behavioural change may take longer.

As people with developmental disabilities move into the community, substance use problems are slowly becoming recognized as an area of concern. Translating this awareness into appropriate treatment strategies will help people with developmental disabilities integrate successfully into mainstream society. ■

*not her real name

Identifying substance use problems in people with developmental disabilities

Diagnostic assessments of substance use problems should consider the following behavioural indicators:

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • significant reduction (from baseline) in compliance with usual schedule, including lateness or missed appointments, work attendance or performance • withdrawal or isolation • increased legal involvement due to assault, theft or disorderly conduct | <ul style="list-style-type: none"> • marked reduction in hygiene skills • abnormal financial problems, including spending, borrowing or lending money • memory impairment • reduced adaptive functioning in areas of judgement, social skills or daily living skills • problems with attention span or concentration | <ul style="list-style-type: none"> • sleep or appetite disturbances • abrupt changes in socialization, including involvement with entirely new group of friends |
|--|---|---|

Source: Kevin Brady, "Substance abuse in the dually diagnosed," *The NADD Newsletter*, v. 10 (5), 1993.

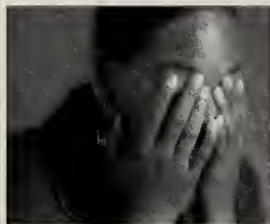
Beyond sexual abuse

Helping women beat the odds

BY DIANA BALLON

FOR YEARS, AMY*, A 38-YEAR-OLD WOMAN WITH A mild developmental disability, went through periods of skin picking and crying for no apparent reason. She was often moody and had low self-esteem and poor eating habits. Her support workers sometimes responded angrily to these phases, assuming that Amy was simply trying to get attention. It wasn't until Amy began to talk aloud to herself about what sounded like past sexual incidents that staff really encouraged her to talk. It came out that as a teenager, Amy had been repeatedly sexually assaulted by a neighbour who had provided her with care.

Unfortunately, Amy's story is not uncommon. An estimated 50 to 80 per cent of people with developmental disabilities have been physically or sexually abused. And women with such disabilities have among the highest rates of abuse of all groups. One study published in a 1991 issue of *Sexuality and Disability* found that nearly 50 per cent of women with developmental disabilities in their sample had been sexually assaulted 10 or more times in their lives.



Intimate partner violence

Negative images and myths about women with disabilities increase their risk of being emotionally abused in intimate relationships. For example, women with disabilities are seen as:

- not able to give or participate equally in intimate relationships
- child-like and dependent

- burdens to their partners and others

- asexual and unable to provide sexual satisfaction to their partners
- And their partners are seen as martyrs or heroes for being in a relationship with them.

Adapted from "Emotional Abuse of Women with Disabilities," Education Wife Assault, at www.womanabuseprevention.com

An abuse history, frequently coupled with other challenges, such as poverty, unemployment, lack of support and dependency, makes people with developmental disabilities more vulnerable to mental health problems – indeed, prevalence rates are estimated to be three to four times that in the general population.

Recognizing abuse may be challenging. People with developmental disabilities may not be able to communicate the abuse. They tend to rely more on others, and may be more easily intimidated by the abuser into keeping quiet. Or, like Amy, their behaviours may simply be viewed as an attempt to gain attention.

Those who receive help with personal care and are used to being touched may also have difficulty differentiating between appropriate and inappropriate touch, says Cheryl Bedard, a therapist at Surrey Place Centre, a Toronto-based agency for people with developmental disabilities. She adds that clients are often taught to be acquiescent – to not question caregivers and others in authority. Sadly, these authority figures are often the ones committing the abuse. The University of Alberta Violence and Disability Project in 1991 found that, of 100 cases of sexual abuse, women with developmental disabilities, over 55 per cent of victims were abused by caregivers.

Despite the high incidence of sexual abuse and its accompanying problems, sexual abuse among women with developmental disabilities is often ignored. Domestic and sexual violence programs and disability services are inadequately prepared to fully understand and meet the needs of these women. According to

the University of Alberta project, treatment services were either inadequate or not offered in 73 per cent of cases.

The lack of treatment services may be partly due to prejudices against people with disabilities. The benefits of psychotherapy for these individuals may be questioned, as well as whether the abuse affects them as strongly as those without disabilities, according to a 1994 article in the *Canadian Journal of Human Sexuality*.

Yet, most people with developmental disabilities who are sexually abused can benefit from therapy, even if they are non-verbal. Dr. Lillian Burke, co-author of the 1994 article, is a psychologist who consults to agencies that serve people with co-occurring developmental disabilities and mental health issues. Rather than dismiss these individuals as being unable to benefit from psychotherapy, Burke focuses on finding the type of therapy best suited to the individual's cognitive and communicative abilities.

Burke says that cognitive-behavioural therapy may be used with higher-functioning clients, while approaches for lower-functioning clients include supportive and symbolic therapies, such as art and play therapy. For non-verbal clients, the therapist can use an augmentative communication system, such as a computer or picture board, to engage the client.

While communication can pose challenges in therapy, clients with developmental disabilities can make themselves understood. Bedard recalls one client who asked her: "How do you draw a picture of your stepfather lying on top of you?"

For Amy, therapy enabled her to explore the abuse she had experienced in a safe setting and learn strategies to start building a sense of confidence for the future.

In some ways, her therapy didn't look much different than it would for anyone dealing with sexual abuse. Initial sessions focused on developing a therapeutic rapport so that Amy could feel safe talking about what happened. And as Amy began to explore the abuse, she expressed many of the feelings of guilt and self-loathing typical of someone who has experienced trauma. Her therapist suggested strategies, such as listening to relaxation tapes, to help her stop injuring herself and cope with her anxiety.

The only real differences in Amy's therapy: Burke took time at the outset to assess Amy's ability to express herself by encouraging her to talk about many things. When Amy had difficulty expressing herself, she and Burke used picture cards to help identify what was happening and how Amy was feeling.

For Amy, the therapeutic process was lengthy, and her memories of abuse won't ever go away. But her story shows that with appropriate treatment and faith in the ability to heal, women with developmental disabilities can move beyond abuse. ■

*not her real name

**Q
& A****Common questions about
dual diagnosis****What is a dual diagnosis?**

Confusion exists around the term dual diagnosis because it is not applied consistently. In Canada, dual diagnosis usually refers to co-occurring mental health problems and a developmental disability. In countries such as the United States, and sometimes Canada, the term is often used to describe concurrent disorders – the co-occurrence of substance use and mental health problems.

**What is a developmental disability?
Is it the same as mental retardation?**

The term “developmental disability” is preferred over the term “mental retardation.” In fact, in Ontario, use of the term “mental retardation” has been repealed in recent legislation because of the stigma associated with it.

Developmental disabilities, such as, Down syndrome, refer to significantly sub-average intellectual functioning, accompanied by significant limitations in adaptive functioning or life skills, with onset before age 18. A person who has a lower than average IQ but who functions with no difficulty in the community may not be diagnosed with a developmental disability. Individuals with pervasive developmental disorders, such as autism, are often included under the rubric of developmental disabilities, even when their IQ approaches the average.

How many Canadians have a developmental disability? A dual diagnosis?

Approximately one to three per cent of Canadians have a developmental disability. Prevalence rates for dual diagnosis are difficult to pinpoint because studies apply different criteria for defining developmental disabilities and mental health problems. For example, definitions of developmental disability may use different criteria in terms of severity of the disability or IQ level. Similarly, mental health problems have been defined inconsistently; for example, some studies may include aggressive and challenging behaviours, while others do not. It is generally agreed, however, that people with developmental disabilities are three to four times as likely to develop

emotional, behavioural and psychiatric difficulties as the general population.

**What are the challenges in assessing
dual diagnosis?**

Individuals with a dual diagnosis present with complex and challenging needs. One diagnostic challenge is being able to differentiate the presence of a psychiatric disorder from manifestations of developmental disability issues. For example, an individual with a developmental disability who has started crying may not get treated for depression because the depressive symptoms may be interpreted as behaviours associated with the developmental disability.

There is also a tendency to medicate or treat what are perceived as symptoms of mental illness when in fact these “symptoms” express unmet needs (medical, environmental or psychological) and legitimate concerns held by the person with the disability. For example, loss of appetite may be a way for the individual to communicate that something is wrong; it may reflect an untreated medical problem or stress at work.

**Given the challenges, how can a dual
diagnosis be accurately assessed?**

A comprehensive assessment includes three components: Getting information from the client at whatever level they can communicate it; direct observation, which can include medical investigation; and informant information. If the client’s ability to communicate is seriously impaired, more information will be obtained from direct observation and informants. Most important in assessment is to compare the client’s behaviours at times of distress to a baseline for that client. For example, if a client with a long-standing habit of skin picking begins to display more of this self-injurious behaviour than usual and in various settings, this may warrant further examination.

**What are effective approaches and
strategies for treatment?**

Literature points to the success of a cross-sector team approach that is integrated within the mental health and developmental sectors’

continuum of supports and services. This multidisciplinary team must agree on realistic expectations and goals to create an effective and comprehensive support system for the client and family. The continuum includes informal and self-help supports; community-based services, such as assessment, treatment, housing, respite, vocational and day programs; and back-up support from specialized services that provide consultation, treatment, education and inpatient care.

Where can I go to find out more?

- CAMH’s Dual Diagnosis Resource Service in Toronto provides time-limited assessment, diagnosis, consultation, treatment and education, (416) 535-8501 ext. 7809
- CAMH’s Dual Diagnosis Service in Peel region provides time-limited assessment, diagnosis, consultation and education, (416) 535-8501, ext. 2870
- Information about and access to the inpatient and day treatment services located at CAMH’s Queen Street site is available through the above phone number
- National Association for the Dually Diagnosed (NADD) is an international association for professionals, caregivers and families to promote understanding of and services for individuals who have developmental disabilities and mental health needs.
www.thenadd.org

Sources: *Creating a Continuum of Support Services* (MATCH project report), 1995, Susan Morris, Mary McGregor-Clewes, Shahrani Mohamed, Bill Gopen; “Epidemiology and prevalence of psychopathology in people with mental retardation,” *Journal of Consulting and Clinical Psychology*, v. 62(1), 1994, Sharon A. Borthwick-Duffy; Susan Morris, clinical director, Dual Diagnosis Program, CAMH; Dr. Yona Linsky, psychologist, Dual Diagnosis Program, CAMH.

HEMA ZBOGAR

Reviews

A Beautiful Mind

This film review is dedicated to the memory of Bill Jefferies, founder of the Canadian Schizophrenia Society and the World Schizophrenia Fellowship, who died on Jan. 18, 2002. To Bill we collectively owe our developing awareness of what can be accomplished when families band together to achieve a common goal. Bill put John Nash's Nobel Prize-winning collaborative game theory into practice.

A BEAUTIFUL MIND IS LOOSELY BASED ON FORMER NEW YORK TIMES economics reporter Sylvia Nasar's biography of John Forbes Nash, Jr., a brilliant mathematician whose PhD work at Princeton University on game theory won him the Nobel Prize in economics in 1994. Forbes has suffered from schizophrenia for most of his adult life.

In the film, the game theory idea comes to Nash (Russell Crowe) in a bar, where he and four colleagues are sitting at a table drinking. In walk five women, one of them strikingly beautiful. All the guys make a beeline for the beautiful one, but Nash stops them: "She's bound to reject you, since she can have anyone she pleases. Once you go for her, the others will snub you, and everyone loses. The winning gambit is to ignore the beauty. Instead, each of you pick one of the other four. That way, at least eight out of 10 people win." According to the movie, this is the stuff of Nobel Prizes. The simplification may not do justice to economic theory, but the visual fade-outs and forefronting of the various possible strategies are brilliant.

The same may be said for the film's depiction of schizophrenia: simplified and misleading, but visually breathtaking. Converting auditory hallucinations into images of people with whom one interacts is a clever cinematographic device. The secret codes that Nash believes are emerging from magazine articles perfectly illustrates the meaning with which schizophrenia imbues the commonplace. The grandiosity and the terror of the protagonist are palpable. The sense of mission, of secrecy, of danger, of certitude, alternating with disquiet, is authentic. Impossible convictions are played out in a manner so believable that the viewer is left to hesitatingly untangle subjective reality from plausible truth. The unwillingness to take medication that sap one's strength and undermine one's

manhood rings true. The initial improvement but eventual disaster of stopping the pills is, alas, also true.

Crowe's portrayal of Nash, from his youthful arrogance and social awkwardness, to his bewilderment and folly, to his post-psychotic vacant stare and neuroleptized gait, is accurate. Yet missing from the film is a sense of the person behind the mathematical madman, his roots, his family, his attachments, his hopes. No personal history is provided that may explain Nash's bizarre beliefs. And the love story with his wife Alicia is built on flimsy wisps.

Instead of exploring the difficulty of the relationship (except for one wonderfully nuanced response by Alicia to a colleague's sympathetic "It can't be easy for you"), the film emphasizes the healing power of love. Psychiatric intervention (Christopher Plummer as the psychiatrist) is shown as more painful than helpful. Instead, Nash and his wife, adrift on a Princeton campus with no close friends, no neighbours, no family relations, no social context except the academic, no reliance on the medical system, make it through on the power of conjugal love.

Love, unfortunately, is not enough in real life. Believing in its healing potential is more delusional than believing, as Nash did, that Russians are planting cryptographic messages in magazines, which he alone has the power to unscramble and decode. Love is not enough to conquer schizophrenia – a lesson Bill Jefferies knew well. It is for this reason that he built federations of families advocating for schizophrenia research.

MARY V. SEEMAN is the former Tapscott Chair of Schizophrenia Studies, University of Toronto.

A Beautiful Mind (2001, 2 hours, 15 minutes) is distributed by Universal Pictures.



Russell Crowe in a scene from *A Beautiful Mind*

Downloaded

Dual diagnosis: untangling the Web

Finding resources on this topic is a challenge. Information is scarce, and the terminology is not applied consistently. The term "dual diagnosis" usually refers to co-occurring mental health and developmental problems, but it is also used to describe co-occurring substance use and mental health problems. In your search, try terms like "developmentally disabled" and "mental health," in addition to "dual diagnosis." Or search for a specific intellectual disability and then look for mental health issues. You may feel uncomfortable using terms such as "mental retardation," but they are still used. When searching a research database, use the subject headings to guide your choice of terminology.

The **Habilitative Mental Health Resource Network** (www.nbpsych.on.ca/habnet/HMHRN.htm) is the Ontario chapter of the National Association for the Dually Diagnosed (NADD). It published a newsletter in addition to conducting workshops and conferences on dual diagnosis.

EnableLink (www.enablelink.org), part of the Canadian Abilities Foundation, is a useful gateway to resources and contacts for people with disabilities.

The **American Academy of Child and Adolescent Psychiatry (AACAP)** published practice parameters for the assessment and treatment of co-occurring "mental retardation" and mental disorders in 1999. For a detailed summary, visit the **National Guidelines Clearinghouse** (www.guidelines.org). Browse by organization, selecting AACAP. Instructions for ordering the complete guidelines are provided. The guidelines are also published in the *Journal of the Academy of Child and Adolescent Psychiatry*.

SHEILA LACROIX

A Parent's Guide to Street Drugs: Ignorance can be as dangerous as drugs

A PARENT'S GUIDE TO STREET DRUGS AIMS TO INFORM PARENTS about street drugs available today, teach parents how to use this information to recognize signs of drug use in their children and suggest where to go for help.

While its intent is commendable, the guide has various shortcomings. It is a Canadian publication, but the statistics cited are predominantly American. It is odd that the author has not included the Ontario Student Drug Use Survey (OSDUS), the longest ongoing school survey of its kind in Canada. Since the inception of the OSDUS in 1977, 52,000 students have been surveyed about their use of alcohol, tobacco and other drugs.

Parents need information and assistance in facing the challenges of parenting in our complicated world. Although the author, James Lang, discusses his belief that the "first and best way to combat drugs in your home is to prevent drug use," the guide seems to emphasize confrontation – how to recognize drug use and paraphernalia and how to confront your child about it.

Many issues must be considered when dealing with suspected drug use in adolescents, in particular issues of privacy and sexuality. Under the guide's section on adulterated urine samples, Lang claims that when providing a urine sample, the adolescent should be observed by a parent or health care technician to ensure the sample is genuine. However, he does not address the humiliation an adolescent would feel if his or her parent or another adult, particularly someone of the opposite sex, is witnessing the sample. And another privacy issue: each section of the guide lists paraphernalia to look for that is associated with various drugs. But Lang does not discuss how secretly looking for paraphernalia may affect the parent-child relationship. Most parents would agree that a teenager's room is sacrosanct and privacy is fiercely treasured. Yet Lang does not stress enough the importance of open communication and a parent-child relationship built on trust.

The guide also inaccurately categorizes various drugs. Lang classifies drugs into four categories: stimulants, depressants, hallucinogens and narcotics. Since narcotics are also depressants, this may confuse readers. Using pharmacological criteria, drugs of abuse generally fall into three categories: CNS depressants (alcohol, opioids, sedative/hypnotics and anxiolytics), stimulants and hallucinogens. Moreover, pharmacologically, narcotics refer

to opioid drugs (morphine, heroin, etc.). However, this may not be the case in legal circles. For example, until the introduction of the Controlled Drugs and Substances Act, cocaine, under the Narcotics Drug Act in Canada, was listed as a narcotic along with the opioids, despite the fact that pharmacologically it is a stimulant.

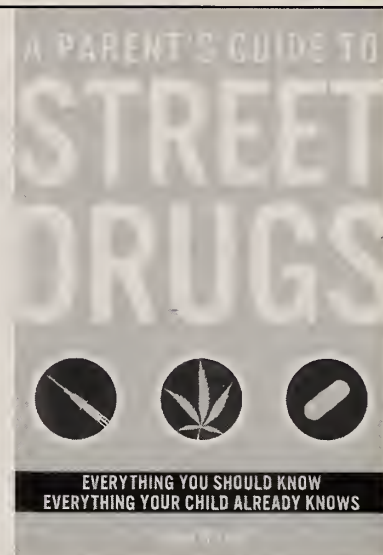
Although Lang writes that the guide has "tried hard to provide ... the most accurate and up-to-date information about street drugs," various other inaccuracies occur.

For example, ketamine is listed as a stimulant, although it is an anesthetic and an analgesic. Similarly, in different parts of the text, GHB is listed as a depressant and as a hallucinogen, although it is generally categorized as a CNS depressant. Concepts are not always clearly presented. Lang does not state what he means by such terms as physical dependence, psychological dependence and withdrawal. Had he done so, apparent inconsistencies might have been explained. For example, Lang states that marijuana and hashish do not produce "physical dependence," yet he lists "withdrawal symptoms" for this drug. It would also have been helpful for the guide to provide information on combining drugs of abuse. For example, using GHB with alcohol is particularly dangerous because both drugs are CNS depressants.

Despite the author's commendable efforts, *A Parent's Guide* cannot be unreservedly recommended.

BRUNA BRANDS is a pharmacologist at CAMH and a co-editor of *Drugs and Drug Abuse: A Reference Text* (3rd ed.).

A Parent's Guide to Street Drugs: Everything You Should Know / Everything Your Child Already Knows. James M. Lang. Stone Fox Publishing, Toronto, 2001, 122 pp., \$12.95.



Books in Brief

Advances in Personality Science

Daniel Cervone, Walter Mischel, eds., Guilford Press, New York, New York, 2002.

This volume lays the foundations for an interdisciplinary science of personality. The contributors present insights and findings from molecular genetics, child and lifespan developmental psychology, neuroscience, dynamic systems theory, evolutionary psychology, social cognition and personality psychology. The book sheds new light on the nature and origins of personality and individual differences. It also challenges many traditional assumptions and points toward compelling new directions for future work in the field.

Drugs in America: A Historical Reader

David F. Musto, New York University Press, New York, New York, 2002.

This anthology puts alcohol and other drug use at the centre of American culture. In accessible, jargon-free language, author David Musto chronicles the rise and fall and rise again of the most popular mind-altering

substances in the United States: alcohol, marijuana, cocaine and opiates. Musto discusses alcohol use among the Puritans and President John Adams' encouragement of hemp production. Excerpts from speeches and medical documents bring to life changing U.S. policy toward alcohol and other drugs.

Psychotherapy and Counselling in Practice: A Narrative Framework

Digby Tantam, Cambridge University Press, Cambridge, UK, 2002.

This book gives a balanced synthesis, based on actual cases, evidence, practice and experience, to describe the process of psychotherapy and identify the fundamental elements that lead to good outcomes across all schools of thought. The author highlights four essential principles for psychiatrists and clinical psychologists looking for a straightforward framework for short-term psychotherapy and anyone using a psychotherapy model with long-term clients.

The Last Word

Compulsory refeeding in anorexia nervosa: beneficial or harmful?

BY ALLAN S. KAPLAN



Editorials do not necessarily reflect the views of CAMH. We welcome submissions from our readers. For information, contact: The Editor, *The Journal of Addiction and Mental Health*, 33 Russell St., Toronto, Ontario M5S 2S1 tel: (416) 595-6714 e-mail hema_zbogar@camh.net

COMPULSORY REFEEDING FOR SEVERELY ILL PATIENTS WITH anorexia nervosa (AN) has presented dilemmas for clinicians for centuries. The physician/philosopher Maimonides stated that a person who does not want to eat should not be forced to eat: "No one forces us, no one decides for us, no one drags us along one path or another ... we are forbidden to deceive anyone about anything ... for example, one must not urge food on another knowing that the other cannot eat." Sir William Gull, who originally described anorexia nervosa in the English language medical literature in 1873, struggled with the notion of imposing treatment on the AN patient. He eventually concluded: "larger experience has shown plainly the danger of allowing the starvation process to go on." In his 1873 clinical description of *l'anorexie hystérique*, the French neurologist Lasegue described waiting for the patient to become receptive to treatment rather than imposing it. More recently, the noted psychiatrist Hilde Bruch wrote, "On principle, anorexic patients resist treatment."

The clinical dangers of untreated severe AN are well known. The mortality rate is the highest of any psychiatric disorder, approaching 20 per cent on long-term follow-up. Given the life-threatening nature of this condition, it is surprising that so little empirical research has been done in this area. This deficiency stems in part from the complex ethical and legal issues that accompany the issue of forced feeding of AN patients.

Ethically, the issue is one of autonomy versus determinism. Those who view compulsory refeeding of AN patients in a potentially life-saving situation as unethical conceptualize anorexia nervosa as a conscious choice, where the individual has the freedom and autonomy to refuse treatment. This view has recently received much attention in the media, attributed in part to the proliferation of very disturbing pro-anorexia Web sites. Critics of compulsory refeeding from an ethical perspective fail to recognize that anorexia nervosa always occurs in the context of a serious mental disturbance. This disturbance is characterized by severely distorted cognitions and self-perceptions that are compounded by the deleterious effects of starvation. The disorder comes to develop a life of its own, in the process robbing the individual of the capacity for clear judgment. Refusing to accept nutritional rehabilitation is part of the core psychiatric symptomatology of the illness. This is not so in the case of a competent medically ill patient who refuses potentially life-saving medical intervention.

Most legal systems recognize the individual's right to refuse medical treatment, even if refusal will hasten or cause death. However, in certain situations, such personal autonomy is overridden by the need to protect individuals from themselves. The law dictates that treatment in a potentially life-saving situation should be imposed in three circumstances: 1) when the individual is judged to be an imminent risk to the self as a

result of mental illness and is involuntarily committed to a facility for treatment; 2) when the individual can be deemed legally incompetent to make decisions regarding medical treatment because of some degree of cognitive impairment; and 3) when the individual is below the age of majority and treatment can be legally imposed by parents or guardians.

The experienced clinician confronted with a severely ill AN patient must weigh the legal responsibility of providing a potentially life-saving intervention with the ethical concerns of imposing treatment against the wishes of the patient in the absence of clear empirical evidence for the long-term benefits of such treatment. Complicating this decision further is the fact that the risk of death in AN is usually related to medical instability and the potential for a sudden cardiac event causing death. This risk is difficult to predict and can fluctuate rapidly. Given such complex considerations, the sensitive, informed clinician must consider five clinical dimensions when deciding whether to impose refeeding: 1) the imminent risk of death if treatment is not imposed; 2) the risk of iatrogenesis, that is, the immediate risks inherent in imposed nutritional rehabilitation; 3) the short-term benefits/risks of the intervention; 4) the long-term benefits/risks of the intervention; and 5) the mental and cognitive competence of the patient. The final decision must be based on a consideration of concepts central to health care ethics: beneficence (the potential benefit to the patient) and non-maleficence (the need to avoid harm to the patient).

Compulsory refeeding should be instituted for the shortest time possible and only until the individual is out of imminent medical danger. It should not be used for a long period in an attempt to fully normalize weight. With an emaciated AN patient who refuses to eat and who has a clearly identifiable medical abnormality (e.g., cardiac arrhythmia) that increases the risk of sudden death and that can be easily corrected through short-term refeeding/rehydration, such intervention should be imposed, as there is clear benefit and little risk of harm to the patient. However, long-term imposed refeeding in a recalcitrant, chronically emaciated patient carries with it less clear benefit and potentially more physiological and/or psychological harm and needs to be pursued with extreme caution. Consultation with an experienced bioethicist can be helpful in such cases. Ultimately, it is crucial for psychiatry to produce empirical evidence clarifying the issue of compulsory refeeding, so that clinicians will be able to make informed, evidence-based decisions about effective care for this very ill and vulnerable group. ■

Allan S. Kaplan, MD, FRCP(C), is the Loretta Ann Rogers Chair in Eating Disorders, head of the Program for Eating Disorders at the University Health Network in Toronto and president of the Academy for Eating Disorders. He is also a professor and director of Postgraduate Education in the Department of Psychiatry at the University of Toronto.

Dear Journal Readers,

As the editorial in this May/June issue indicates, starting in September, we will be moving to quarterly publication, with more pages per issue. This change in schedule means that there will be no July/August issue. We hope that you will enjoy the new, expanded journal.

If you have any concerns please contact a customer service representative at 1-800-661-1111 or 416-595-6059 in the Toronto area.

We look forward to your continued readership.



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11.2.1. The Group

Let G be a group and let H be a subgroup of G .

Let $a \in G$ and let $b \in H$.

Then $ab \in H$ if and only if $a \in H$.

Proof. Suppose $a \in H$. Then $ab \in H$ because H is a subgroup.

Conversely, suppose $ab \in H$. Then $a = (ab)b^{-1} \in H$ because H is a subgroup.

Therefore, $ab \in H$ if and only if $a \in H$.

Q.E.D.

Corollary 11.2.1. Let G be a group and let H be a subgroup of G .

Let $a \in G$ and let $b \in H$.

Then $aH = Ha$ if and only if $a \in H$.

Proof. Suppose $a \in H$. Then $aH = Ha$ because H is a subgroup.

Conversely, suppose $aH = Ha$. Then $a \in Ha$ because $a \in H$.

Therefore, $aH = Ha$ if and only if $a \in H$.

Q.E.D.

Corollary 11.2.2. Let G be a group and let H be a subgroup of G .

Let $a \in G$ and let $b \in H$.

Then $aH = Ha$ if and only if $a \in H$.

Proof. Suppose $a \in H$. Then $aH = Ha$ because H is a subgroup.

Conversely, suppose $aH = Ha$. Then $a \in Ha$ because $a \in H$.

Therefore, $aH = Ha$ if and only if $a \in H$.

Q.E.D.

Corollary 11.2.3. Let G be a group and let H be a subgroup of G .

Let $a \in G$ and let $b \in H$.

Then $aH = Ha$ if and only if $a \in H$.

Proof. Suppose $a \in H$. Then $aH = Ha$ because H is a subgroup.

Conversely, suppose $aH = Ha$. Then $a \in Ha$ because $a \in H$.

Therefore, $aH = Ha$ if and only if $a \in H$.

Q.E.D.

Corollary 11.2.4. Let G be a group and let H be a subgroup of G .

Let $a \in G$ and let $b \in H$.

Then $aH = Ha$ if and only if $a \in H$.

th,

Conferences

CANADA

Alcohol and Drug Addiction Association – Strength through Collaboration

June 2–4, 2002, Mississauga, Ontario
Contact: Mary Napper,
tel (519) 624-8855
e-mail mary@highonlife.org
web www.adrao.on.ca

21st International Human Science Research Conference

June 19–22, Victoria, British Columbia
Contact: IHSRC 2002, PO Box 3030,
c/o Continuing Studies, University of
Victoria, Victoria, BC V8W 3N6
tel (250) 472-4747
e-mail ihsrc@uvic.ca
web www.uvic.ca/ihsrc2002

23rd Congress of the Collegium Internationale Neuro-Psychopharmacologicum

June 23–27, Montreal, Quebec
Contact: Sarah Markey, Congress
Manager, ICMS Pty Ltd, 84 Queensbridge
Street, Southbank, Victoria, Australia
tel 61 3 9682 0244
fax 61 3 9628 0288
web www.vanderbilt.edu/CINP/

4th Conference of the Society for the Psychological Study of Social Issues

June 28–30, Toronto, Ontario
Contact: SPSSI Central Office, 1901
Pennsylvania Ave., NW, Ste. 901,
Washington, D.C., 20006-3405 USA
tel (202) 223-5100
fax (202) 223-5555
e-mail sspencer@watarts.uwaterloo.ca
web www.spssi.org/2002.html

11th World Congress of Psychophysiology

July 29–August 3, Montreal, Quebec
Contact: International Organization of
Psychophysiology, World Congress
Secretariat, Conference Department,
Elsevier Science, The Boulevard, Langford
Lane, Oxford OX5 1GB, UK
tel 44 0 1865 843691
fax 44 0 1865 843958
e-mail sm.wilkinson@elsevier.co.uk
web www.elsevier.com/locate/iop2002

International Society for the Study of Behavioural Development's 17th Biennial Meeting

August 2–6, Ottawa, Ontario
Contact: ISSBD, School of Psychology,
University of Ottawa, 120 University St.,
Ottawa, ON K1N 6N5
tel (613) 562-5799
fax (613) 562 5147
e-mail issbd@uottawa.ca
web www.issbd.uottawa.ca

T 2002: 16th International Conference on Alcohol, Drugs and Traffic Safety

August 4–9, Montreal, Quebec
Contact: Elizabeth Wells-Parker, ICADTS
Secretary, Mississippi State University,
Mississippi State, Mississippi 39762, USA
tel (601) 325-7959
fax (601) 325-7966
e-mail bwparker@ssrc.msstate.edu
web www.saaq.gouv.qc.ca/t2002/

World Forum Montreal 2002: Drugs, Dependencies and Society – Impacts and Responses

September 22–27, Montreal, Quebec
Contact: Forum Mondial Montreal 2002
tel (514) 529-3030
fax (514) 340-4440
e-mail secretariat@worldforumdrugs-
dependencies.com
web www.worldforumdrugs-
dependencies.com

52nd Annual Meeting of the Canadian Psychiatric Association

October 31–November 3,
Banff Springs, Alberta
Contact: CPA Head Office, 260-441
MacLaren St., Ottawa, ON K2P 2H3
tel (613) 234-2815
fax (613) 234-9857
e-mail agm@cpa-apc.org

UNITED STATES

32nd Annual Meeting of the Jean Piaget Society – The Embodied Mind and Consciousness: Developmental Perspectives

June 6–8, Philadelphia, Pennsylvania
Contact: Eric Amsel, Department of

Psychology, Weber State University,
1202 University Circle, Ogden, UT
84408-1202
e-mail eamssel@weber.edu
web www.piaget.org

American Psychological Society 14th Annual Convention

June 6–9, New Orleans, Louisiana
Contact: Meeting Coordinator
tel (202) 783-2077
web www.psychologicalscience.org

10th World Congress on Pain

August 17–22, San Diego, California
Contact: International Association for
the Study of Pain, Secretariat,
909 NE 43rd Street, Suite 306,
Seattle, WA 98105
tel (206) 547-6409
fax (206) 547-1703
e-mail IASP@locke.hs.washington.edu
web www.iasp-pain.org

National Association of Rural Mental Health 28th Annual Conference – Riding the Winds of Change:

Alternatives for the Journey
August 26–29, Sante Fe, New Mexico
Contact: LuAn Rice
tel (320) 202-1820
web www.narmh.org/conferen.htm

Treating Addictions in Special Populations: Research Confronts Reality

October 7–8, Binghamton, New York
Contact: Jane Angelone, Conference
Coordinator, Professional Development
& Research, Binghamton University, PO
Box 6000 (AB-130), Binghamton, NY
13902-6000
tel (607) 777-4447
fax (607) 777-6041
e-mail angelone@binghamton.edu
web www.sehd.binghamton.
edu/pdr/index.htm

54th Institute of Psychiatric Services

October 9–13, Chicago, Illinois
Contact: American Psychiatric
Association, Meetings Management
Department, 1400 K Street, NW,
Washington, DC 20005
tel (202) 682-6100

fax (202) 682-6114
e-mail apa@psych.org
web www.psych.org

49th Annual Meeting of the American Academy of Child and Adolescent Psychiatry

October 22–27,
San Francisco, California
Contact: Julie Morgan, American
Academy of Child and Adolescent
Psychiatry, 3615 Wisconsin Ave., NW,
Washington, DC 20016-3007
tel (202) 966-7300
fax (202) 966-2894

33rd Annual Meeting of the American Academy of Psychiatry and the Law

October 24–27,
Newport Beach, California
Contact: 1 Regency Dr., PO Box 30,
Bloomfield, CT 06002-0030
tel (860) 242-5450
fax (860) 286-0787
e-mail execoff@aapl.org

43rd Psychonomic Society Annual Meeting

November 21–24, Kansas City, Missouri
Contact: 1710 Fortview Rd.,
Austin, TX 78704
tel (512) 462-2442
fax (512) 462-1101
e-mail rsanford@psychonomic.org
web www.psychonomic.org/meet.htm

36th Annual Convention of the Association for Advancement of Behavior Therapy

November 14–17, Reno, Nevada
Contact: Association for Advancement
of Behavior Therapy, 305 Seventh
Avenue, 16th flr, New York, NY
10001-6008
tel (212) 647-1890
fax (212) 647-1865
web www.aabt.org/

International Neuropsychological Society

February 5–8, 2003, Honolulu, Hawaii
Contact: INS, 700 Ackerman Rd., Ste.
550, Columbus, OH 43202

Cont'd...

tel (614) 263-4200
 fax (614) 263-4366
 e-mail osu_ins@postbox.acs.ohio-state.edu
 web www.osu.edu/ins/meetinfo.html

ABROAD

The International Institute of Forensic Studies, Inaugural Conference – "Expert Evidence: Causation, Proof and Presentation"

July 2–5, Prato, Tuscany, Italy
 Contact: Jenny Crofts, 41 Davison St., Richmond, Victoria, 3121 Australia
 tel 61 3 9429 2310
 fax 61 3 9421 1682
 e-mail jennycrofts@ozemail.com.au
 web www.law.monash.edu.au/iifs

XIV International Conference on AIDS

July 7–12, Barcelona, Spain
 Contact: AIDS 2000 Barcelona, Pomaret 21, 08017, Barcelona, Spain
 tel 34 93 254 0555
 fax 34 93 254 0575
 e-mail aids2002@aids2002.com
 web www.aids2002.com/IE_Home.asp

8th World Association for Infant Mental Health Congress

July 16–19, Amsterdam, The Netherlands
 Contact: WAIMH Executive Office, Institute for Children, Youth and Families, Kellogg Center # 27, Michigan State University, East Lansing, MI 48824
 tel (517) 432-3793
 fax (517) 4432-3694
 e-mail waimh@msu.edu
 web www.msu.edu/user/waimh

International Biennial Conference on Self-Concept Research: Driving International Agendas

August 6–8, Sydney, Australia
 Contact: Kate Johnston, SELF Research Centre, University of Western Sydney, Bankstown campus, bldg 1, Locked Bag 1797, Penrith South DC NSW 1797, Australia
 tel 61 2 9772 6428
 fax 61 2 9772 6432
 e-mail k.johnston@uws.edu.au
 web edweb.uws.edu.au/self

18th World Congress of Psychotherapy

August 14–18, Trondheim, Norway
 Contact: WCP-02, Department of Child and Adolescent Psychiatry, Norwegian University of Science and Technology, 30 MTF, No. 7489, Trondheim, Norway
 tel 47 7386 7140
 fax 47 7386 7166
 e-mail wcp-02@medisin.ntnu.no
 web www.wcp2002.no/

XVI European Conference on Philosophy of Medicine and Health Care

August 21–24, Qawra, Malta
 Contact: Department of Ethics, Philosophy and History of Medicine, University Medical Center, PO Box 9101, 6500 HB Nijmegen, The Netherlands
 tel 31 24 361 5320
 fax 31 24 354 0254
 e-mail h.tenhave@efg.kun.nl

XII World Congress of Psychiatry

August 24–29, Yokohama, Japan
 Contact: XII World Congress of Psychiatry, c/o Convention Linkage, Inc., Akasaka Nihon Bldg., 9-5-24 Akasaka Minato-ku, Tokyo, 107-0052 Japan
 tel 81 3 5770 5549
 fax 81 3 5770 5532
 e-mail wpa_sec@c-linkage.co.jp
 web wpa2002yokohama.org

7th International Conference on the Treatment of Sexual Offenders – "Sexual Abuse and Sexual Violence: From Understanding to Protection and Prevention"

September 11–14, Vienna, Austria
 Contact: Reinhard Eher, International

Association for the Treatment of Sexual Offenders, University of Vienna Medical School, Vienna, Austria
 e-mail office.iatso@medacad.org
 web www.medacad.org/iatso/

3rd International Early Psychosis Conference – "A Bridge to the Future"

September 25–28, Copenhagen, Denmark
 Contact: International Early Psychosis Association, Locked Bag 10, Parkville, VIC 3052, Australia
 tel 61 3 9342 2837
 fax 61 3 9342 2941
 e-mail iepa@vicnet.net.au

10th World Congress on Psychiatric Genetics

October 9–13, Brussels, Brabant, Belgium
 Contact: Christine Van Broeckhoven, International Society of Psychiatric Genetics, 122 Avenue de l'Atlantique, 1150 Brussels, Belgium
 tel 32 2 779 5959
 fax 32 2 779 5960
 e-mail wcp2002@iceo.be

28th International Conference – "Coming of Age: A Celebration of Mental Health Nursing"

October 15–18, Sydney, New South Wales, Australia
 Contact: Sue Butterworth, Conference Secretariat, GPO Box 2609, Sydney NSW 2001, Australia
 tel 61 2 9241 1478
 fax 61 2 9251 3552
 e-mail mental@icmsaust.com.au

15th International Congress: The International Association for

Child and Adolescent Psychiatry and Allied Professions

October 29–November 2, New Delhi, India
 Contact: The Secretariat, Savita Malhotra, Professor of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh 160 012, India
 tel 91 172 747 585 ext. 521
 e-mail savita@ch1.dot.net.in
 web www.childindia.org

16th International Hypnosis Congress

August 2–8, Singapore
 Contact: Secretariat, ICMS Pty Ltd., 84 Queensbridge Street, Southbank, Victoria, Australia 3006
 tel 61 3 9682 0244
 fax 61 3 9682 0288
 web www.icms.com.au/16ish

VIII World Congress of Biological Psychiatry

September 28–October 3, Buenos Aires, Argentina
 Contact: WCBP 2003 Congress Secretariat, Congresos Internacionales S.A., Moreno 584, 9th Floor (1091), Buenos Aires, Argentina
 tel 54 11 4342 3216/3408
 fax 54 11 4331 0223/4334 3811
 e-mail conginte@congresosint.com.ar

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AND MENTAL HEALTH

Autumn 2002
Volume 6
Number 1

Ethics

**Clinical trials
with vulnerable
populations**

**Reporting laws
weave tangled
web for
addiction
clinicians**

**Psychiatric
institutions
move to
enshrine
client rights**



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de santé mentale

WHEN MOTHERS HURT
The hidden shame of
post-partum depression

CONCURRENT DISORDERS
Report urges integration
of services

PRESCRIBING HEROIN
Dutch study suggests new
directions for treatment



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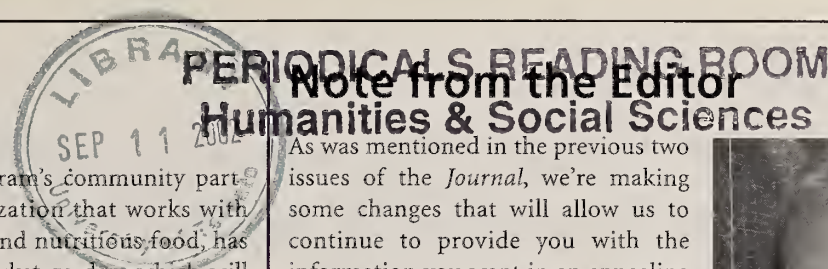
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Cover

Sun Turtle, Ron Hyatt (Little Turtle), acrylic on canvas, 42" x 42"

Ron has been doing arts and crafts since he was a teenager. His media have been wood, leather, and now acrylic on canvas.



News from the Centre

CAMH garden takes root

The Schizophrenia and Continuing Care Program's community partnership with FoodShare, a non-profit organization that works with communities to improve access to affordable and nutritious food, has expanded to include the development of a market garden, which will grow and sell vegetables to FoodShare's Good Food Box. The garden, which is located on the west site of CAMH's Queen Street property, provides paid work experiences for CAMH clients. To learn more, call Monica Bettazzoni at (416) 535-8501 ext. 2619.

A night of heroes and humanitarians

On May 2, the CAMH Foundation hosted its ninth Courage to Come Back Awards and Dinner. Almost 900 people attended to hear the stories of seven courageous award recipients. This annual event is a major initiative that helps break down the stigma attached to mental illness and addiction. The money raised by this event will help the Foundation fund important work at CAMH.

Queen Street site redevelopment plans move forward

A major focus for CAMH over the past few years has been planning the redevelopment of the Queen Street site. CAMH reached another milestone in this process earlier this year with the completion of the Functional Program (a description of proposed programs and services, facilities and staffing) and the Facilities Master Plan (a translation of the Functional Program into a physical plan). These documents were submitted to the Ministry of Health and Long-Term Care (MOHLTC) in April. Since then, CAMH has met with MOHLTC to review the plan. We hope to get approvals and funding for the site redevelopment by spring 2003. We have also submitted an official plan and rezoning application for the site to the City of Toronto, which is currently reviewing our plans. For up-to-date news on the project, please check our Web site at www.camh.net.

CHRISTA HAANSTRA

Note from the Editor Humanities & Social Sciences

As was mentioned in the previous two issues of the *Journal*, we're making some changes that will allow us to continue to provide you with the information you want in an appealing format. Following a readership survey sent out with the January/February issue, we reviewed the mandate of the *Journal* and decided to implement some changes to reflect what readers find most useful. As such, this is the first quarterly issue, with more pages, which will allow more in-depth stories on topics that interest you.



To more fully reflect the knowledge transfer mandate of the Centre for Addiction and Mental Health, the *Journal's* publisher, we are refocusing our target audience to emphasize professionals, frontline workers and other allied professionals, particularly those in community-based agencies, among whom there is a need to be better served and informed through publications.

The *Journal* will also have a new name, expected to be launched with the Winter 2002 issue, to more clearly reflect the *Journal's* mandate – to emphasize a focus on both addiction and mental health issues.

The *Journal* remains committed to providing accurate, informative coverage of issues relevant to the mental health and addiction community. I encourage you to send copies of the *Journal* to your professional colleagues, encouraging them to subscribe.

In the meantime, we hope you enjoy this issue of the *Journal*, which focuses on ethical concerns in the mental health and addiction fields. Balancing the values, beliefs, needs and concerns of clients, their families, mental health and addiction professionals and the community can create complex, intricate moral conundrums. While the law affords some guidance and protection, it does not always resolve the issues.

Tamsen Tillson and Hema Zbogor's story about clinical trials with vulnerable populations discusses the tension that exists between furthering science and protecting individual rights and well-being. Astrid van den Broek discusses the conflict that addiction clinicians face in providing treatment while following impaired driving reporting laws. The move by psychiatric institutions to protect inpatient rights is the focus of Vicki O'Brien's story. And Lisa Schmidt discusses the ethical dilemma of providing adequate care for older adults with psychiatric and addiction issues in a system where resources are limited.

The Last Word piece about ethical and legal issues regarding safe injection facilities in Canada is timely. Recently, the Canadian HIV/AIDS Legal Network released a report entitled *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, which concludes that Canada has a legal and moral obligation to allow for and fund trials of safe injection facilities as part of an overall strategy to more effectively respond to harms related to drug use.

We always welcome your input to the magazine. It is your feedback that helps us evolve. Let us know how we are doing. Or write a letter to the editor expressing your thoughts on our stories.

HEMA ZBOGOR

Tel (416) 595-6714

e-mail hema_zbogor@camh.net



Letters to the Editor

Addiction acupuncture a useful adjunctive therapy

The May/June 2002 issue of the *Journal* included a summary in the Research Update section entitled "Acupuncture ineffective treatment for cocaine addiction." It is important to note that the summary referred to the results of a study evaluating the National Acupuncture Detoxification Association (NADA) 5-point ear acupuncture protocol as a stand-alone treatment modality. The NADA acupuncture protocol, known as Acudetox, is not intended to be utilized as a stand-alone modality.

NADA states, and many research studies support, that Acudetox is a highly useful adjunctive therapy in the treatment of cocaine dependency and other addictions. The Centre for Substance Abuse Treatment, which is the U.S. government agency responsible for federal funding of addiction treatment programs, considers the accumulated research findings valid enough to plan nationwide implementation of Acudetox.

Kimberly Murdoch
Stress Management Therapist
CAMH

Help for gambling addictions goes on-line

I am the Webmaster of an on-line self-help group for compulsive gamblers. The name of our site is Compulsive Gamblers Hub (CG Hub). We are a non-profit, self-supporting Web site. Our purpose is to share our experience, strength and hope with one another, and to be a place

of support for those seeking help for a gambling addiction. We support the Gamblers Anonymous (GA) principles and guidelines but are not formally a part of GA.

This site was put into place immediately following the "crash" of the GA Web site to which you refer in Nate Hendley's story about on-line self-help groups in the January/February 2002 issue of the *Journal*. Since its inception in July 2001, the site has grown very rapidly and is helping untold numbers of people with gambling problems every day. Many new and exciting things are happening in this medium. We are currently in the process of bringing "live" talk and video to our on-line meetings. Please feel free to contact us.

For more information about CG Hub, contact the Webmaster, Charles P., at cp044@bellsouth.net, or visit the Web site at cghub.homestead.com/index.html.

Linking child abuse and schizophrenia

We are concerned that through your research update headline, "Child abuse may trigger schizophrenia," in the May/June 2002 issue, you may be making the classic mistake of confusing cause and effect. There are certainly other explanations for the correlation between child abuse and adult onset schizophrenia. May we present one.

Families of adults with schizophrenia will tell you that "he/she was always different." That is, years before overt psychotic symptoms brought the child or adolescent to the attention of the mental health system and enabled a psychiatrist to diagnose schizophrenia, they exhibited disturbing behaviour. They did not do well in school, they weren't considerate of others, they had poorly developed social skills, they isolated themselves from friends and family, they didn't do their share of household chores. Any of these behaviours in a family milieu that condones physical punishment might trigger abusive parental responses and might certainly trigger a lot of shouting and screaming or verbal abuse. So an explanation for the correlation between child abuse and schizophrenia could equally well be that schizophrenia causes child abuse.

Obviously, in reporting this research, it is premature to ascribe cause and effect. You are a quasi-scientific journal with a mandate to educate as well as communicate. You represent a respected scientific institution with a reputation to protect. "Correlation" does not necessarily mean a cause and effect relationship. This is misleading, unscientific journalism.

Bridget Hough
President
Schizophrenia Society of Ontario, Toronto Chapter

Response from the editor

Our mandate at the *Journal of Addiction and Mental Health* is indeed, as you say, to educate as well as communicate. It is also our mandate to provide our readers with a variety of perspectives on the issues we explore. The research updates we publish do not necessarily reflect the views of the *Journal* or the Centre for Addiction and Mental Health. They are provided to encourage discussion among addiction and mental health professionals and those in their care. In this case, the headline simply reflected the study's findings.

Public Information & Education RESOURCES

The Centre for Addiction and Mental Health, a World Health Organization Centre of Excellence, is committed to making available resources that provide better understanding, prevention and care in the fields of mental health and addiction.

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Our information booklets, brochures and pamphlets include, among others, a "road rage" test, guidelines for low-risk drinking, general information about trauma and

its effects, fact sheets about addictive substances, a booklet to help women identify the effects of trauma in their lives, and a number of mental health promotion resources for immigrants new to Canada.

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de santé mentale

Limited quantities of these resources are free to Ontario residents.

New clinic takes sex outside the bedroom

HEALTH, MARRIAGE, FINANCIAL SECURITY AND PERSONAL SAFETY may be jeopardized when a person with a sexual addiction pursues a "fix." Sexual addiction afflicts people in all walks of life – including Hollywood celebrities, a U.S. president and even a television evangelist. And it has been gaining notoriety in recent years.

Growing concern about the issue has prompted Bellwood Health Services, a private addiction clinic in Toronto, to develop a special treatment program for sexual addictions.

Sex is a basic human need, part of the joy of life, but for people with sexual addictions it becomes much more. Often, it's a response to emotional scars or problems in other areas of their lives. "The greater the pain, the better the fix feels," says Rob Hawkings, program development specialist at Bellwood. And make no mistake, Hawkings says. "Sex is a very, very powerful addictive fix to somebody who is vulnerable."

The gratification parallels the effect of drugs. "We know that similar neuropharmacological processes are involved with sexual fantasy as with the hallucinogenic drugs," Hawkings says. The satiation response is similar to the depressant effect of alcohol, and the arousal response can be likened to the central nervous system arousal of stimulants.

The Bellwood program, which takes up to eight participants at a time, is divided into two three-week portions. The initial three weeks involve intense psycho-educational work, focusing on understanding sexual addiction and the recovery process. During the second three weeks,

the program zeroes in on relapse prevention skills. Group and drama therapy, as well as life development, skills development are provided throughout the six weeks.

In addition to group work with fellow clients and sessions with family members, clients build a relationship with a counsellor, who continues to work with them after they have left the clinic. "They will get several years of fairly intensive support following their graduation," explains Hawkings. That may include mini-programs, aftercare groups, one-on-one sessions with counsellors and 24-hour-a-day access to telephone support. "According to our outcome studies, involvement in aftercare is the single most powerful predictive factor in how well people do in terms of maintaining their sobriety after treatment," adds Hawkings.

In the case of sexual addiction, sobriety doesn't mean celibacy. Clients are taught about healthy sexual activity, while developing a "personal abstinence list" of problem behaviours. "They're learning what they need to eliminate and how to effectively eliminate those things from their lives," Hawkings says. "At the same time, they're learning what healthy sexuality is about, so they can begin replacing the dysfunctional behaviours with healthy behaviours."

STEPHEN NICHOLLS

For more information, contact Bellwood Health Services Inc., 1020 McNicoll Ave., Toronto, ON M1W 2J6, tel (416) 495-0926, ext 145, toll-free 1 (800) 387-6198, web www.bellwood.ca.

Diagnostic criteria for sexual addiction

- pattern of out-of-control behaviour
- inability to stop the behaviour, despite adverse consequences
- persistent pursuit of self-destructive or high-risk behaviour
- ongoing effort to limit the problematic behaviour
- use of sexual obsession and fantasy as a primary coping strategy
- increasing amounts of sexual experience
- severe mood changes around sexual activity
- inordinate amounts of time spent in obtaining sex, being sexual or recovering from sexual experience
- neglect of important social, occupational or recreational activities

Other things to watch for:

- marital difficulties
- increasing isolation from family and friends
- signs of compulsively avoidant behaviour (e.g., loss of interest in sex)
- depression connected to sex or sexual behaviour
- history of sexual, physical or emotional abuse
- describing sex life in self-medicating terms (e.g. intoxicating, relieves tension or pain)
- predilection to high-risk or self-destructive behaviour other than sexual
- greater arousal by high-risk sexual behaviour than safer sexual behaviour
- presence of other addictive disorders
- history of deception around sexual behaviour
- use of language reflecting disgust or self-loathing about sexual behaviour
- few emotionally intimate relationships that aren't sexual

SOURCE: Sexual Addiction Assessment Form SA-4, Meadows Institute, Wickenburg, Arizona

Can I Catch It like a Cold?

A story to help children understand a parent's depression



Children have lots of questions when someone in their family becomes ill. When that illness is depression, it often becomes a secret that nobody talks about.

Can I Catch It like a Cold? tells the story of eight-year-old Alex and his struggle to understand his father's depression. This engaging storybook answers key questions children have about depression, offering a starting point for a discussion about the disorder. Written for children aged five to nine years old, this resource is for use by parents, extended family, teachers and mental health professionals who want to address the impact of depression in children's lives.

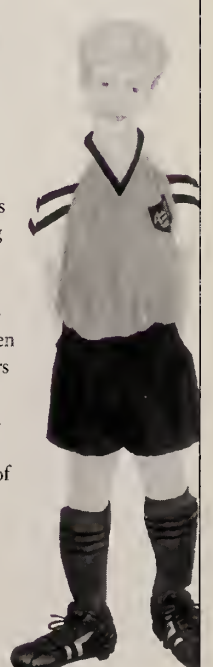
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Report urges integration of concurrent disorder services

"This admission, that admission, this specialist, that specialist, but nobody's really doing anything, nothing's really getting done, just a whole bunch of appointments going nowhere."

THIS KAFKA-ESQUE SITUATION MAY SOUND LIKE A COMEDY OF errors – but the comment is no joke. This type of experience, related by consumers of mental health and addiction services in focus groups across the country, was part of the impetus behind the creation of the *Best Practices: Concurrent Mental Health and Substance Use Disorders* document.

Health Canada, Canada's Drug Strategy (CDS) and the Centre for Addiction and Mental Health (CAMH) released the document late last year. It is a tool to steer practice, help integrate services and, hopefully, keep clients with co-occurring mental health and substance use problems from falling through the cracks.

"We view it as a living document," says Cathy Airth, acting director of CDS. "This is the sum of the knowledge we have to date, and we hope it gets maximum visibility in the service delivery area."

The need for a synthesis of research and recommendations for screening, assessment, treatment and support was clear. A recent Ontario study found that 55 per cent of people with an alcohol dependency diagnosis also had a mental health diagnosis. Separate initiatives across Canada identified individuals with concurrent disorders as a priority population. Still, many treatment models have addiction and mental health services working in isolation and often from competing perspectives.

One of the document's main recommendations is that people seeking help from mental health and/or addiction services be screened for co-occurring disorders. Approaches can be as simple as asking a few questions based on an index of suspicion. Higher-level techniques may use more detailed, codified scales and indexes.

Wayne Skinner, clinical director of the Concurrent Disorders Program at CAMH, says the existence of concurrent disorders should be thought of as the rule, rather than the exception. "We need to have it as our assumption that clients have a very high likelihood of having problems in both mental health and addiction domains."

Clinicians are encouraged to see assessment as an ongoing process that will take time. This step is critical in sorting out what is called the "chicken and egg" problem of distinguishing co-occurring disorders.

Linda Sibley-Bowers, executive director of Alcohol and Drug Services of Thames Valley in London, Ontario, is pleased to see the inclusive and progressive definitions of integrated treatment. "New in this document is the notion that you can treat concurrent disorders in a parallel way, a chronological way or a concurrent way – and they're all OK. If you have a substance use problem and an eating disorder, this document recognizes that you might have to focus on the eating disorder first. I see that as an evolution."

Skinner sees the regionalization of addiction and mental health services in some provinces as a promising development, putting both services in the same domain. In British Columbia, for example, addiction treatment services are back in the province's health department, after years in another portfolio. "That puts mental health and addictions together into one division," says Dr. John Anderson, medical consultant for the Mental Health and Addiction Division, B.C. Ministry of Health. "That sends a clear message that centrally, we see the two areas as related."

It is still early for most provinces to have specific plans to integrate treatment, but Skinner says that many jurisdictions are beginning to embrace the idea, with a high level of interest in training and skill building. B.C. has already begun spreading the word. "We have facilitated dissemination to health regions and also had Brian Rush from CAMH (project team leader for the document) out here to Victoria to do a one-day workshop," says Anderson.

Sibley-Bowers says that London has hosted a series of free seminars about concurrent disorders for clinicians. She expects the document will be discussed with the local District Health Council, where plans for system-wide integration will begin.

Dr. John Campbell, senior co-ordinator of Adult Mental Health Programs, Halifax Department of Health, says Nova Scotia recognizes the issue, but so far, most activity has been ad hoc and local.

Some point out that the document raises more questions – such as how to deal with specific populations like the elderly or people with special needs. But Skinner says it's a work in progress. "Sometimes people want to do things, but they get stalled because they don't know how to shape new practice. I think there is some energy around this. It doesn't answer all the questions, but it does help people move forward."

CINDY MCGLYNN

Best Practices: Concurrent Mental Health and Substance Use Disorders has been well received; but there may be one sticking point for some clinicians. The report defines concurrent disorders based on the DSM-IV definition, which uses a medical model that researchers worry may be out of harmony with current addiction treatment methodology.

"In most provinces, the service delivery model for substance use problems was traditionally a sort of non-medical, 12-step model," says Dr. John Campbell, senior co-ordinator of Adult Mental Health Programs, Halifax Department of Health. "This is changing, but there are still some major philosophical differences."

"We tend to have a more client-centred approach – asking clients to discuss what their condition means to them," says Linda Sibley-Bowers, executive director of Alcohol and Drug Services of Thames Valley.

But Sibley-Bowers sees the DSM-IV definition as a communication tool rather than a power transfer. "I think (project leader) Brian Rush was very clear that it's not about handing over treatment to the medical community. The DSM definition is clear, it is concise and it is an opportunity to professionalize our understanding of community-based help. It allows us to have a common language."

Take 1000 mg of heroin and call me in the morning?

MEDICALLY PRESCRIBING HEROIN TO PEOPLE ADDICTED TO THE drug has been debated for more than 20 years in the Netherlands. So it seems timely that the Dutch government commissioned the Central Committee on the Treatment of Heroin Addicts to study the effectiveness of prescribing heroin in combination with methadone for people addicted to heroin who are treatment resistant.

Of the estimated 25,000 people addicted to heroin in the Netherlands, approximately half are in treatment. However, close to 60 per cent of those are not benefiting sufficiently, despite a comprehensive addiction treatment system that includes low-threshold methadone maintenance programs as well as long-term, intensive, therapeutic community treatment.

Between 1998 and 2001, 549 treatment-resistant individuals were recruited from methadone maintenance programs in six cities across the Netherlands. Two parallel studies were conducted: one involved intravenous administration of heroin and the other inhalable heroin. The experimental groups received heroin and methadone for six or 12 months, after which the heroin was discontinued. The experimental groups were compared to control groups, which received 12 months of methadone-alone treatment. Daily maximum dosages of methadone and heroin were 150 mg and 1000 mg respectively. Psychological counselling was offered to all groups. Outcomes were measured in terms of physical and psychological health; social functioning, including involvement in criminal activity; cocaine consumption; and illicit heroin use.

"This is a landmark study," says Dr. Benedikt Fischer, assistant professor of Public Health Sciences and Criminology at the University of Toronto and a research scientist at the Centre for Addiction and Mental Health (CAMH). "It's the first methodologically rigorous study using randomized controlled trials that explores the effects of prescription heroin treatment for problematic heroin addicts."

The most important finding was that supervised co-prescription of heroin and methadone resulted in greater improvement than methadone-alone treatment, regardless of route of administration, in all health outcome domains. Among the injectors and inhalers, there was a difference of 25 and 23 per cent respectively between the experimental and control groups. Although the participants in the experimental groups were still addicted, their quality of life improved. However, just two months following discontinuation of prescription heroin, all the gains had disappeared and the participants had deteriorated to their original dysfunctional levels.

"On the basis of these findings, we advised the government to implement medically supervised and highly controlled prescription heroin and methadone to chronic, treatment-resistant heroin addicts as a last-resort pharmacological treatment," says Dr. Vincent Hendriks, senior scientist on the study.

Some experts are more cautious. "What they're really doing is adding methadone to a heroin program, not heroin to a methadone program," says Dr. Herbert Kleber, director of the Division on Substance Abuse at Columbia University in New York. "They're giving methadone to people addicted to heroin to hold them between their heroin doses. But they're still getting high and still risking all the dangers of injecting. Heroin doesn't change their lifestyle or reintegrate them into society," claims Kleber. "It's a dreadful maintenance drug."

Hendriks concedes that it is difficult to ascertain whether it is the pharmacological effects of heroin that are solely responsible for the

improvements in clients. "You don't get healthy from heroin by itself," he says. "It must be some combination of the substance itself, that it's offered in a well-equipped treatment centre along with additional basic care, that it can be taken three times per day which perhaps also structures their lives, and that the heroin is available without having to worry about stealing money to buy it. This is very different from the everyday life of an illicit heroin user."

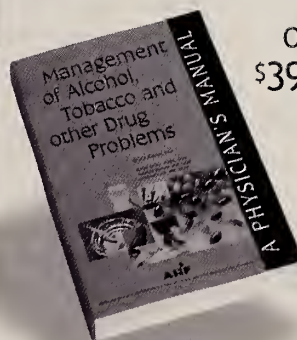
Although he is not against the use of heroin treatment, Dr. Marc Shinderman, national medical director of the Center for Addictive Problems (CAP Quality Care) in Chicago, Illinois, believes the efficacy of methadone may not have been evaluated fairly. "In general, I've found that methadone treatment, as practised around the world, is deficient in terms of doses and flexibility of schedule that is administered to get a result," says Shinderman. "In our programs, when we dose people aggressively in response to continuing heroin use, we've knocked use down by 97 per cent or more. So treatment failures are not the failure of methadone as an agent, but the failure of the practitioner."

Nevertheless, heroin is a lightning rod for many people's real or political concerns. "Many are ideologically opposed to addicts being given drugs by the health system that make them feel good," says Fischer. "But the idea of maintenance treatment is to reduce mortality, morbidity and other social harms – to keep people healthy and alive."

Meanwhile, the Dutch team is continuing to do secondary analyses and further studies. "We hope that in different countries there will be initiatives that will repeat and supplement our findings," says Hendriks. "There are still many questions to be asked."

HONEY R. FISHER

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Research Update

Cigarette smoke – that's what girls are made of

Parents who smoke around the time of a child's conception may increase the likelihood that the child will be a girl. Researchers at the Fukuda Ladies Clinic in Hyogo, Japan, reached this conclusion after studying the smoking habits of the parents of 11,815 babies delivered between December 2000 and July 2001. The researchers gathered data on each parent's cigarette consumption during the periconceptional period, from three months before the last menstruation to the time of the pregnancy's confirmation. They found that where neither parent smoked, there were 1.2 boys born for every girl born. Where both parents smoked more than 20 cigarettes a day, there were 0.8 boys born for every girl. Male births were almost as low when only the mother smoked heavily, and the father smoked fewer than 20 cigarettes a day. But only a small number of couples fit this description. The researchers note that these findings may help explain the decline in the ratio of male to female children observed in developed countries such as Denmark, England, Germany, the United States and Canada. Chronic exposure to environmental toxins appears to have a greater effect on males and the male reproductive system.

Lancet, April 20, 2002, v. 359: 1407-1408. Misao Fukuda et al, Fukuda Ladies Clinic, Hyogo, Japan.

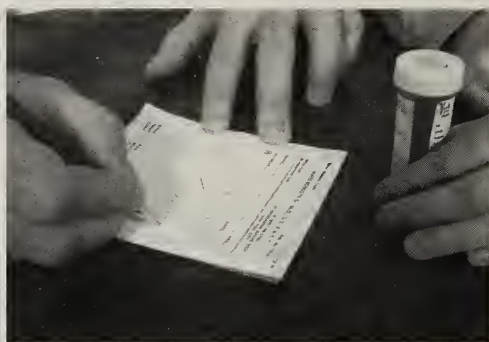
Placebo's effect on brain similar to Prozac

Treatment of depression with placebo results in many of the same changes in brain function as treatment with the antidepressant Prozac (fluoxetine). Researchers at the University of Texas Health Science Center in San Antonio treated 15 depressed men for six weeks with either placebo or Prozac in a random double-blind study. Four of those given a placebo and four given Prozac responded to treatment, with comparable improvement in their symptoms. Positron emission tomography (PET) scans at the end of treatment showed that the placebo resulted in many of the same changes in brain metabolism as those caused by Prozac. However, the magnitude of the changes was usually greater with Prozac, and Prozac resulted in additional

changes in the brainstem, striatum and hippocampus. The researchers note that previous research has suggested that the long-term outcome with placebo is poorer than with an active drug, and it is not clear whether the differences seen in this study make those who responded to placebo more prone to relapse. The placebo effect has long been an expected part of antidepressant therapy, and these findings may help clinicians take fuller advantage of the brain's own compensatory capacity.

American Journal of Psychiatry, May 2002, v. 159 (5): 728-737. Helen S. Mayberg et al, Rotman Research Institute, Baycrest Centre, University of Toronto, Toronto, Ontario.

Antipsychotic doses may be higher than necessary



How we dose antipsychotic medications in illnesses such as schizophrenia may warrant re-evaluation, based on recent findings. This is the implication of new research from the Centre for Addiction and Mental Health in Toronto. Scientists used positron emission tomography (PET) scans to track levels of the antipsychotics olanzapine and risperidone in the brains of 10 healthy volunteers and five individuals being treated for schizophrenia. The researchers found that blood levels dropped off more rapidly than levels in the brain. While blood levels for both drugs dropped to 50 per cent of peak values within a day, it took several days for levels in the brain to fall to 50 per cent of peak values. The researchers indicate that these results call into question current reliance on dosing schedules based on blood levels, since it is the presence of antipsychotic medication in the brain that influences their effectiveness. If these results are supported by further study, it may be possible to adjust dosing for antipsychotic medications, with the goal of lowering total doses. This would

lessen the drugs' often troubling side effects without compromising their therapeutic effect. However, the researchers caution that it is premature for doctors and clients to start changing doses based on the study; rather, the findings should spur more careful clinical trials.

Molecular Psychiatry, May 2002, v. 7 (3): 317-321. J. Tauscher et al, Centre for Addiction and Mental Health, University of Toronto, Toronto, Ontario, University of Vienna, Vienna, Austria.

Single gene triggers violent behaviour in mice

The loss of a single gene is all it takes to turn normal mice into violent killers. Mice born missing the gene *Nr2e1* display such dramatically violent behaviour that they have been dubbed the "fierce" mutation. Accidentally discovered in Germany, the mutation has been mapped by a team of American and Canadian scientists. Fierce males repeatedly attacked their siblings, often killing them, and either wounded or killed females during mating experiments. One variety of fierce females also displayed a dramatic increase in aggressive behaviour, and fierce females in general lacked normal maternal behaviour. Corticosterone and testosterone levels were found to be normal among fierce mice, and thus not related to increases in aggression. The mutation also resulted in a number of physical abnormalities, including stunted growth, poor development of the fore-brain and abnormalities of the retina and optic nerve. The authors note that although the *Nr2e1* gene is also found in humans, it is not clear whether deletion of a single gene could have such a profound effect on human behaviour.

Behavioral Brain Research, May 2002, v. 132: 145-158. Kelly A. Young et al, Departments of Biochemistry and Molecular Biology, Johns Hopkins School of Public Health, Baltimore, Maryland.

Group therapy may be best for minor disorders

Group psychotherapy may be more effective than traditional clinical management in the treatment of minor psychiatric disorders, at least in the short term. Researchers at the University of Sao Paulo in Brazil recruited 83 people with mild or moderate affective disorder,

anxiety, somatoform, adjustment and sexual problems. Half received eight sessions of Brief Group Dynamic Psychotherapy (BGDP) over one month, where they addressed issues through techniques such as questioning, discussion and timed confrontation. The other half received one month of traditional clinical management, involving individual treatment by a psychiatrist, which included medication, advice or manipulation of the environment. At month's end, twice as many of those in the BGDP group reported improvement in their mental health. However, when interviewed at two-year follow-up, participants in the BGDP group appeared to be in poorer health than those in the clinical management group. The researchers suggest that one possible explanation for the poorer long-term performance of the BGDP group is that eight sessions were too few to have a lasting benefit.

British Journal of Psychotherapy, May 2002, v. 180: 416-422.

Sergio Luis Blay et al, Department of Psychiatry, Federal University of Sao Paulo, Sao Paulo, Brazil.

Internet could increase number of problem gamblers



People who gamble on the Internet are more likely to be problem gamblers than those who engage in more traditional forms of gambling, according to research from the University of Connecticut Health Center. Of 389 patients at the Center who filled out questionnaires, eight per cent reported gambling on the Internet, and four per cent gambled on the Internet at least once a week. All reported some form of gambling during their lives. Among Internet gamblers, 74 per cent were classified as either problematic or pathological gamblers. Only 22 per cent of those without Internet gambling

experience were so classified. Younger participants were more likely to be Internet gamblers, as were non-Caucasian participants. The authors conclude that as Internet use increases, the numbers of problem gamblers will also increase. This in turn means that more people will fall victim to the problems associated with gambling, including substance use problems, risky sexual behaviour, circulatory disease, depression and anxiety. The health care system may face an additional challenge of identifying and treating people with gambling-related problems.

Psychology of Addictive Behaviors, March 2002, v. 16 (1): 76-79. George T. Ladd and Nancy M. Petry, Department of Psychiatry, University of Connecticut Health Center, Farmington, Connecticut.

Risk of alcohol dependency may be detected in blink of an eye

Adult children of parents with alcohol dependency have been found to exhibit limited emotional reactions to unpleasant images, which may serve as an early indicator of susceptibility to alcohol-related problems. Researchers at the Veterans Affairs Medical Center in Oklahoma City, Oklahoma, studied 30 young adults with a family history of alcohol dependency (FH+) and 30 with no such family history (FH-). Participants were considered FH+ if they had a biological father with two or more alcohol-related problems. Eye blink electromyograms were used to measure participants' startle response to colour photographs of pleasant, neutral or unpleasant objects or scenes. When shown unpleasant photographs, FH+ participants had smaller eye blinks than FH- participants, with no difference in reaction to pleasant or neutral photographs. These differences held even though there was no difference between the two groups in subjective perception of the pleasantness or unpleasantness of the photographs. The researchers suggest that since limited response to aversive stimuli (such as discipline or the ill effects of substance use problems) appears from previous research to be a predictor of risk for alcohol dependency, the eye blink test may prove to be a useful tool in identifying those at risk.

Alcoholism: Clinical & Experimental Research, April 2002, v. 26 (4): 441-448. Robert Miranda, Jr. et al, Veterans Affairs Medical Center, Oklahoma City, Oklahoma.

Naltrexone may reduce urge to steal



The drug naltrexone, often used in the treatment of alcohol addiction and other urge-related disorders, may reduce the urge to steal among people with kleptomania. Researchers at the University of Minnesota studied 10 outpatients who reported stealing an average of just over two times a week, two of whom had been arrested for stealing. The trial included an initial treatment with placebo, followed by 11 weeks of treatment with naltrexone. One original recruit responded to placebo and was excluded. The 10 included in the study were those who completed at least one week on naltrexone. By the study's end, two participants reported that they no longer experienced the urge to steal, while eight reported that their urges were significantly reduced, making them easier to resist. Only one individual continued to steal, while the other nine reported no stealing for an average of four weeks. Participants also experienced improvements in their work and social lives. Naltrexone acts as an antagonist of opioid receptors involved in processing reward, pleasure and pain, and participants in this study appeared to experience less pleasure associated with stealing. The researchers conclude that although further study is required due to the small sample size, the results indicate that naltrexone has promise in treating a disorder with considerable social and economic cost.

Journal of Clinical Psychiatry, April 2002, v. 63 (4): 349-356. Jon. E. Grant and Suck Won Kim, Department of Psychiatry, University of Minnesota School of Medicine, Minneapolis, Minnesota.

MARK DE LA HEY

When new motherhood hurts – the hidden shame of post-partum depression

"I felt I was completely on the bottom rung. A complete failure as a mother, as a wife, as a person."

"Each time I faced the decision to seek help, I felt more anxiety and delayed it – until I reached what I felt was a crisis state."

THESE WORDS, FROM WOMEN WITH histories of post-partum depression (PPD) at a recent focus group discussion in Hamilton, Ontario, describe pain that is compounded and deepened by shame: a common experience for those affected by post-partum mood disorders.

Studies show that depressed mood following childbirth affects 45–80 per cent of women and is acute enough to warrant a diagnosis of PPD in about 12 per cent of cases. Dr. Shaila Misri, a Vancouver specialist in PPD, calls it "the single most frequently occurring complication of pregnancy."

Origins of the disorder are manifold. Dr. Jean Francois Saucier, a professor of psychiatry at the University of Montreal, says: "There are many points of departure: PPD is the end point. Biology may lend a woman a particular fragility, and then life events may play a part too."

Although "the baby blues" are a commonly recognized phase of new motherhood, the true

range and depth of emotional difficulties following childbirth is often missed by health care providers. Missed diagnoses are due in part to the complex array of causes and symptoms presented by PPD, and in part due to the continued stigma of depression – complicated further by unrealistic social expectations of motherhood.

In the words of one woman with PPD: "You have it all – or at least, a beautiful child in your arms – and all you want to do is cry, or hide or worse. You feel pretty crazy and are not too likely to just let people know, especially not a doctor." Dr. Bill Watson, a family physician at Toronto's St. Michael's Hospital, sees the same dynamic at play in his practice: "A woman has just had a lovely child and is feeling absolutely miserable. She feels embarrassment and shame about disclosing this. Some women will go to the nth degree to hide what is going on."

Other factors that may prevent a woman from seeking help include lack of initiative and energy (stemming from the depression) and fears that a mental health diagnosis will result in authorities taking away the baby from the mother. Also, manic state sometimes occurs in the post-partum period – and although just as harmful to the mother and baby as is depression, it may cause the mother to feel as though

she does not need help. Grazyna Mancewicz, a social worker with the Maternal Support Program at St. Joseph's Health Centre in Toronto, says that cultural and linguistic differences also often get in the way of diagnosis: "In the instances where we do translate for the mother (into Spanish, Polish, Chinese and Tamil), we have to say "baby blues" in English – because there is no easy way of identifying the problem in other languages."

A study conducted by Misri and reported in her 1995 book, *Shouldn't I Be Happy?*, shows that the average time between onset of symptoms and support-seeking by Canadian women is seven months. "They wait until they are desperate," says Misri. Furthermore, once a mother eventually does seek help, her health care provider may miss the signs and fail to identify PPD. Saucier reports the case of one Quebec mother who recently went to her local emergency department in a crisis and was diagnosed as having insomnia. She was given sleeping pills, and appeared three more times at the same hospital, receiving the same diagnosis. After her fourth emergency visit, the woman overdosed on the pills. Only at this point did she receive the correct diagnosis – and a prescription of antidepressant medication to help treat her mood.

Contacts

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Misdiagnosis stems from a variety of factors, one of which is overloaded resources. Watson says that psychiatry is in short supply, even in large cities such as Toronto, where women can wait months just for an assessment. He also feels that physicians are often busy, with too many clients, and don't spend the time necessary to assess a problem.

Failure to identify PPD can also stem from the fact that, interestingly, a mother may actually be over-intrusive toward, rather than neglectful of, her baby, and thus may seem outwardly to be a very effective, non-depressed mother. Behind the scenes, however, she may be suffering painful guilt because she does not feel as happy as she had expected to feel, and is unable to be what Saucier terms "psychologically present" for her child.

Many experts believe that another factor hampering diagnosis of PPD is the fact that, as a society, we tend to emphasize the health of the baby over the health of the mother in the postpartum period. The correct questions simply go unasked in many instances.

Furthermore, as Mancewicz says: "A woman can be extremely depressed one day and the next may have a better day. It's not always a textbook-clear situation. It represents itself in such different ways: one mother might be

crying; one might be agitated. Both are miserable, both will say, 'I'm not myself.'" With such a wide variety of symptoms, PPD is easy to miss; yet failure to diagnose in a timely fashion can lead to painful or even dangerous crisis situations for mother and child.

Training health care providers to diagnose PPD is an important step. Christine Long, executive director of Postpartum Adjustment Support Services of Canada (PASS-CAN), states: "There is a real need to teach doctors how to respond, to put the pen down and take a few minutes. Traditionally, the response has often been, 'It's just your hormones – try to get out to a movie or shopping,' or 'Here's a script – come back in a month.' We need to train physicians' ears to hear what is being said."

More effective screening to identify women most at risk would significantly reduce the harm of PPD. Health Canada's nationwide "Healthy Babies, Healthy Children" program – intended to protect families from a range of problems including PPD – varies widely in quality and scope from region to region, so that many mothers are never screened. Long says that when it comes to PPD prevention, "the purpose of the program is to provide seamless service: but there is a lack of dollars and a lack of political will."

ABIGAIL PUGH

Identifying PPD

The following factors may increase a woman's risk of developing PPD:

- hormone sensitivity (i.e., premenstrual syndrome or depression induced by contraceptive use)
- previous experience of PPD
- history of depression or bipolar disorder
- family history of depression or bipolar disorder
- few social supports

When assessing a new mother for PPD, caregivers should look beyond the obvious. A sufferer will experience any or all of the following:

- exhaustion
- irritability
- hopelessness
- insomnia
- appetite changes
- difficulties concentrating
- excessive worry
- crying for "no reason"
- no interest or pleasure in the baby
- guilt
- hot sweats or palpitations
- lack of interest in others
- scary thoughts about harming the child

Christine Long says that many PPD sufferers mask their mental state very effectively. If given the opportunity to merely engage in social pleasantries and conceal her true distress, a sufferer will usually take this route. This means that caregivers and doctors should proactively and specifically ask the following questions:

- Are you able to sleep when the baby is sleeping?
- Are you eating normally, in terms of types and quantity of food?
- Are you able to get out of the house?
- Are you experiencing any scary thoughts about your baby?

Source: PASS-CAN



The human side of drug farming

LAST WINTER, THE GOVERNMENT OF COLOMBIA LAUNCHED A major military offensive against leftist guerrillas. Government soldiers, some of them riding U.S.-made helicopters, attacked troops from the Revolutionary Armed Forces of Colombia (FARC, in Spanish).

The war in Colombia has been going on for decades and taken countless lives. Caught in the crossfire are poor, peasant farmers, many of whom cultivate coca (the base ingredient in cocaine) to survive. The peasants are exploited by FARC and terrorized by government forces, which receive training and equipment from the United States. The situation in Bolivia is equally grim; over the past few months, there have been several violent confrontations between coca farmers and police.

Like their counterparts in Afghanistan, who raise opium poppies, used to make heroin, South American farmers cultivate coca because they lack better options. "For the most part, it's a matter of common sense. You can grow coca and feed your kids, or not," says Sanho Tree, drug policy director at the Institute for Policy Studies, a progressive think-tank in Washington, D.C.

This state of affairs is attributable to the fact that "the state has abandoned the countryside," says Tree. "We're talking about no infrastructure whatsoever – no electricity, no running water, police, schools or health care ... [these services] are either non-existent or minimal." Not surprisingly, many poverty-stricken peasants willingly choose to plant coca, a hardy plant that grows easily in rugged terrain and brings in two or three or four times as much money than so-called legal crops, says Tree.

Bolivian farmers face similar conditions, reports Kathryn Ledebur, co-ordinator of the Andean Information Network (AIN), a Bolivian watchdog group that documents human rights abuses in the war on drugs. "In Bolivia, coca growers grow coca to insure their subsistence," she states.

Ledebur estimates that 35,000 families in the Chapare region of Bolivia (a flashpoint for recent violence between farmers and police) produce coca. Each family tends small coca plots, which average 40 square metres, spread out over several hectares. These tiny coca parcels can earn a farmer about \$100 a month, says Ledebur, compared with \$35 a month for palm plants, which take longer to mature and require more pesticides.

Raising coca, however, is a risky business; in the past year, 10 coca growers have been killed in clashes with Bolivian law officers. In response to such attacks, coca farmers have organized themselves into unions. These growers associations have enough clout to bring government officials to the bargaining table to discuss ways to end endemic violence in the region.

Coca producers have also flexed their muscles on an international level. In 1998, a South America-wide organization called the Andean Council of Coca Leaf Growers (CAPHC) issued a declaration at a United Nations conference on drugs. CAPHC urged delegates to recognize the difference between coca and cocaine. Coca, which has been grown for thousands of years, is used by South Americans as a mild stimulant and a tonic to ward off hunger, altitude sickness and exhaustion. Cocaine, on the other hand, has only been around since the 19th century. It is produced by chemical synthesis and is primarily used for its euphoric effects. It is legal to consume coca for medicinal or traditional purposes in much of South America, making farmers all the more reluctant to stop growing it.

Afghani farmers have been proven equally unenthusiastic about efforts to stamp out the opium trade, a business that has flourished in their country for hundreds of years. According to *Global Illicit Drug Trends 2001*, a comprehensive study by the United Nations, Afghanistan produced 3,276 metric tons of opium – or 70 per cent of the world's total – in 2000. Following a crackdown by the brutal Taliban regime, opium production dropped off 91 per cent for the 2000/2001 growing season. After the Taliban were defeated, Afghani farmers returned to one of the few cash crops available to them. A report released in February by the U.N. International Narcotics Control Board predicts that the opium harvest in Afghanistan in 2001 might rival that of 2000.

Likewise, coca still flourishes in South America, despite billions of dollars in aid from the United States. Some anti-coca initiatives, such as aerial fumigation, have actually been counter-productive, says Tree. By destroying their livelihood, Colombian authorities have embittered farmers and made them ripe for recruitment by FARC. Other peasants have simply burrowed deeper into the countryside to plant more coca.

A recent study by the United States General Accounting Office states that crop substitution programs have also failed in Colombia and elsewhere. "The Colombian government does not control many coca-growing areas, it has limited capacity to carry out sustained interdiction operations, and its ability to effectively co-ordinate eradication and alternative development activities remains uncertain," according to the report.

In an interview published last December in *Narco News*, an independent media outlet reporting on drug wars, Bolivian farmer/activist Fructuoso Herbas offered another reason why anti-drug efforts in Third World countries rarely succeed. "When we stopped growing coca we worked planting pineapple, palm, other fruits," states Herbas. "But there is nowhere to sell these fruits. There is no market... We don't know what is going to happen. And the government just shoots bullets."

NATE HENDLEY



A farmer picks coca leaves in Colombia.

Checks and balances

Psychiatric institutions move to enshrine client rights

BY VICKI O'BRIEN

MATT, AN INVOLUNTARY CLIENT AT RIVERVIEW Hospital, a psychiatric institution in British Columbia, is upset to see an unfamiliar blue pill mixed in with his regular medication. When told it's a new anti-psychotic drug prescribed by his psychiatrist, Matt refuses to take it. "Dr. Wilkinson never said anything to me about any new medication," he tells his nurse. "It could be poison for all I know." "Matt, don't give me a hard time," sighs the nurse. "If you don't take it, I'll give you a PRN injection. You really need this medication."

According to mental health clients, former clients and advocates across the country, this type of scenario, indicative of the power imbalance between staff and clients, is commonly played out in Canada's psychiatric institutions. But in this particular case, Matt and his nurse are professional actors who assumed their unusual roles as part of an interactive multi-media training program helping clinical staff integrate the hospital's seven-year-old Charter of Patient Rights into daily practice.

In the above scenario, staff violated three key client rights: Matt's psychiatrist prescribed a new medication without discussing it with him. As a result, the doctor breached Matt's right to participate in his treatment and his right to get a full explanation of it – regardless of his ability to give consent. By threatening to give Matt a PRN injection, the nurse also violated his right to be free from chemical and physical restraint, except in an emergency.

Riverview began developing its Charter of Patient Rights in 1991. The process was accelerated in 1994 when, following well-publicized complaints from clients and their families, the provincial government ordered B.C.'s ombudsman to carry out a hospital-wide review. The final report contained 94 recommendations, mostly relating to inadequate client advocacy and complaint mechanisms.

In response to the recommendations, administration fast-tracked the laborious process of drafting a rights document, obtaining input from clients, families, advocates, lawyers and hospital staff groups and planning and implementing a major training program. When finally approved in 1995, the ombudsman described Riverview's charter as the strongest and most detailed statement of its kind, addressing key issues such as responsive internal complaint and client advocacy mechanisms and better quality assurance controls.

Embedding the Charter into Riverview's culture meant revising dozens of policies and procedures, making changes to hospital infrastructure and educating clients, families, staff and a broad range of outside stakeholders. A key part of this education process was developing an interactive CD-ROM featuring more than a dozen video case studies. All clinical staff members are required to go on-line to study the Charter and its clarifying statements. They must successfully complete a self-test section covering the Charter's 45 social, therapeutic and legal rights; the relationship between clients' rights and responsibilities; and the workings of the dispute resolution process.

"Over the last seven years, the Charter has become an integral part of the social fabric of this hospital," says Phil Bell, coordinator of clinical projects at Riverview. "Obviously, in an institution of this size, there will be pockets of resistance. But with education, eventually you'll get a critical mass of staff who will naturally incorporate respect for patient rights into daily practice."

But as mental health clients and advocates are quick to point out, such documents are mere words unless clients and their families are fully aware they exist, unless the rights are guaranteed and unless clients and families have easy access to a timely, responsive dispute resolution process.

According to David Simpson, a systemic policy adviser in Ontario's Psychiatric Patient Advocate Office (PPAO), client rights initiatives are now an essential part of the checks and balances of Canada's mental health system. In 1983, the provincial government established the PPAO within the Ministry of Health and Long-Term Care to protect the legal and civil rights of clients in the province's 10 psychiatric hospitals.

"I believe the best approach is to ensure the broadest possible interpretation of patient rights. Otherwise there's a danger that a very detailed bill will become inflexible and stagnate. Ideally, it should become a rights promotion document that becomes even more responsive over time," says Simpson.

The Centre for Addiction and Mental Health (CAMH) in Toronto is among a number of Canadian psychiatric institutions struggling with how best to enshrine client rights into the system. Empowerment facilitator Jennifer Chambers is working with a committee of clients, family members, mental health advocates and CAMH staff to produce a bill of client rights. Currently in the consultation phase, it is a much shorter document than the one produced by Riverview. It contains 10 basic client rights, each with a set of elaborating statements.

"We have the advantage of learning from people who have gone before," says Chambers. "As a result, our bill is more comprehensive and less detailed than Riverview's charter. We've tried to keep it powerfully yet simply worded to make it as accessible as possible to those who need it most."

In one of the biggest departures from the Riverview approach, the CAMH bill will not include a section on client responsibilities. "We understand that Riverview acceded to staff pressure on this issue," says Chambers. "But the entire purpose of a bill of rights is to improve the disparity in power between clients and staff. Staff has the support of employment standards legislation, labour unions and professional associations, plus they get to go home at night. Our clients have none of those things." ■



Client rights initiatives are now an essential part of the checks and balances of Canada's mental health system.

Putting human research on trial

Research with vulnerable populations raises ethical issues

BY TAMSEN TILLSON AND HEMA ZBOGAR

A 25-YEAR-OLD HOMELESS MAN WITH SCHIZOPHRENIA is experiencing terrible side effects from an antipsychotic drug that isn't very effective. He is offered \$200 to go off that drug and begin taking a new drug as part of a clinical trial that researchers believe may work better than his current medication.

Although this hypothetical situation seems simple – try something new to replace what isn't working – , it has ethical implications: is it acceptable to offer a clearly attractive financial reward for participating in research where the outcome may not be beneficial and may in fact harm the participant, and which the individual may turn down if the compensation were less attractive?

Being aware of and avoiding potential abuses in research, whether subtle or more covert, is crucial for researchers, particularly in recruiting members of vulnerable populations – in this case, people with mental health and addiction problems.

Excluding such individuals from research may seem to be the best assurance against abuse, but it is not the answer. Recruiting vulnerable populations is in no way unique to mental health or addiction research, says Dr. Padraig Darby, co-chair of the Research Ethics Board at Toronto's Centre for Addiction and Mental Health (CAMH). Whether it be diabetes or schizophrenia the researcher is studying, "you can only answer some questions by studying the population of those who have the illness," explains Darby.

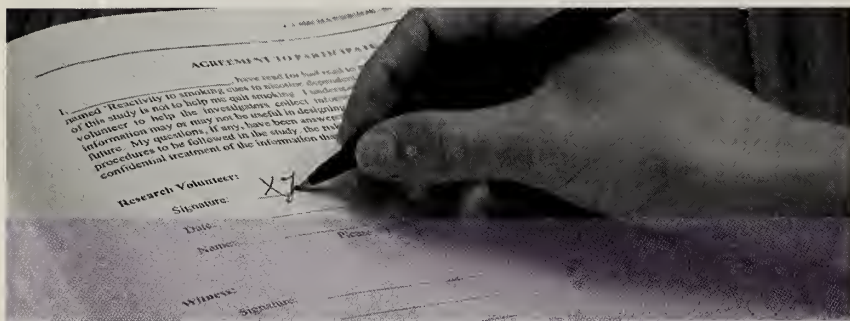
Running clinical trials, particularly with vulnerable populations, is a delicate task in which study participants' rights must be protected and their autonomy respected. Research ethics boards (REBs) – which decide whether proposed clinical trials are warranted and can proceed – must ensure that participants are fully informed and have consented to participate freely and without coercion. "Informed consent is always fundamental to human research, based on the principle of autonomy and respect for persons," says Susan Pilon, manager of the Research Ethics Office at CAMH.

Most REBs in Canada follow several sets of guidelines for these reviews, which must include the Tri-Council Policy Statement. But none of the current guidelines contain special provision for study participants with addiction or psychiatric problems. And for good reason, opines Darby, who says there is a misplaced assumption that participants with mental health issues in particular are automatically incapable of providing informed consent. A specialized set of guidelines would only feed into this misconception.

Instead, REBs start with the assumption that study participants are capable of consent, as indeed, most are. If investigators wish to use "incapable" participants (individuals who are not able to understand information about the treatment or who are not able to appreciate the consequences of making or not making a decision about the treatment), they must justify their use before the REB, and get the consent of the participant's legal guardian. John Simpson, co-chair of CAMH's REB, adds, "you also give the individual an opportunity to provide assent." Assent means that the participant has been informed about what is going to happen and has agreed to what will transpire within what may be a limited degree of understanding. As with anyone, incapable individuals do not participate if they say they don't want to.

Consent must be provided without coercion. Dr. Cynthia Geppert, a psychiatrist and senior research fellow of the University of New Mexico Health Sciences Center Institute for Ethics, says that participants with psychiatric or addiction problems often have what she calls "double vulnerabilities"; that is, participants with mental health or addiction problems are often members of ethnic minority groups or they may be impoverished, homeless, physically ill or older. Because of these vulnerabilities, incentives to participate, such as free therapy or simply medical attention, may exert undue coercive influence over their decision to participate. And these individuals may easily assume – rightly or wrongly – that their care will suffer if they refuse to participate.

For this reason, researchers who are also clinicians cannot ask their own clients to participate in their research: such a request may be seen as coercive in that the individual may feel pressured to please the caregiver. This form of coercion may extend to support staff or others on whom the client relies for care. "If a nurse or someone the patient knows is important to that patient's comfort, for example, in toileting, and the



Changes afoot that could affect REBs and research participants

Health Canada is considering getting involved in the governance of the oversight of research involving humans, notes Richard Carpentier, executive director of the National Council on Ethics in Human Research in Ottawa, Ontario. One of the proposals is the accreditation of REBs, something that was initiated more than a year ago in the United States. Other proposals include research ethics education for the research community and a national level ethics review of certain types of research that may involve serious conflicts of interest, socially significant research, high-risk research and multi-centred and community-based research.

Susan Pilon, manager of the Research Ethics Office at CAMH, notes that in general there is an international trend to create more stringent safeguards in the use of clients in research. In Ontario there is privacy legislation pending dealing with personal health information, which – if it passes in the fall – will have an impact on research.

"The best protections for vulnerable patients are well-trained, staffed and supported review boards, and investigators who have the training to conduct research that is sound both scientifically and ethically."

patient antagonizes that person, there may be retaliation," says Dr. Bernard Dickens, a professor at the University of Toronto's Faculty of Law and a member of the university's Joint Centre for Bioethics. "If you antagonize the people you depend on, you'll be relegated an unimportant person and may not be treated well. That form of coercion is a risk, not just for investigators recruiting participants, but for support staff," adds Dickens.

"Between clinical practice and research, there is a very strict line in terms of who obtains consent that's designed to eliminate the power relationship that exists between the medical system as a treating system and the power of those in charge of it," says Simpson.

There are also those who participate out of misplaced hope, known as therapeutic fallacy. These are individuals seeking a cure or a better treatment than they are currently receiving. For example, forensic clients in prison may see participation in research as a ticket to better care in prison.

"The potential participant may think, 'If I enter this trial I'll be cured. Something is better than nothing,'" says Simpson. "Well, something may not be better than nothing. You have to be careful to point out that this is a potential new treatment. We don't want participants entering the trial because they think it will cure them," he adds. In fact, new treatments bring the risk of potentially harming participants, a possibility that must be made clear to individuals before they agree to participate.

Compensation is another issue. Participants may be compensated, but payment can't be so attractive as to motivate an impoverished individual to participate in a study in which that person otherwise would not have. And there is always the risk that participants with substance use problems may use that money to buy illegal drugs. "You have to look at recruitment in terms of whether people are highly vulnerable and whether they are being talked into participating because they need something," says Simpson.

To get around the problem, incentives can be carefully weighed so that study participants are fairly compensated for their time, discomfort and inconvenience, but are not so significant that they become coercive, explains Geppert. For instance, many trials provide a small fee for transportation and meals.

Despite these challenges, the solution is not to disregard clients by barring them from participation in clinical trials. Rather, research must be conducted with integrity and competence and institutional safeguards must be in place to protect clients. This is where REBs come in. "The best protections for vulnerable patients are well-trained, staffed and supported review boards, and investigators who have the training to conduct research that is sound both scientifically and ethically," says Geppert.



National placebo guidelines sought

Canada could become the first country in the world to develop a national policy governing the scientific and ethical use of placebos in the evaluation of new medications. The National Placebo Initiative (NPI) is a joint initiative of Health Canada and the Canadian Institutes of Health Research (CIHR) in Ottawa. The NPI was formed to develop new, uniform policies to address the many ethical and regulatory issues surrounding the use of placebos in clinical trials. Developing a national policy will help REBs across the country to more easily make decisions by consulting a checklist of criteria, such as the amount of risk to participants and the need for such a study. The National Placebo Working Committee, made up of people representing various stakeholders, is developing proposals, which will then be passed on to Health Canada and the CIHR for approval. The recommendations are expected to be completed in the spring.

However, REBs themselves face challenges. Dr. Richard Carpentier, executive director of the National Council on Ethics in Human Research in Ottawa, is concerned that many REBs are "badly supported" and that this problem is increasing. Most REBs are made up entirely of volunteers, who, in addition to their regular jobs, assess around 250 research projects every year. "These people have to be trained and supported properly because the workload is very heavy and the support is very often not sufficient," notes Carpentier. "Often there's not enough money to learn what you have to learn." But efforts are underway to address these shortcomings. (See sidebar.)

"It is unlikely that we will ever be able to develop safe and effective treatments, or even cures, for psychiatric disorders and addictions without the participation of persons who suffer from these conditions," says Geppert. "Most patients and family members, we have found, understand this and strongly support research and the participation of vulnerable populations with strong ethical safeguards." ■

To report or not to report

Laws weave tangled web for addiction clinicians

BY ASTRID VAN DEN BROEK

CONSIDER TWO SCENARIOS: AN ADDICTION CLIENT shows up for an appointment with a therapist or physician completely intoxicated. Another client is being assessed for the first time by a therapist and mentions having recently driven home from a party, but insists on having been sober.

Such situations are regularly encountered by therapists and physicians, and while the solution to the first one is crystal clear – suggest alternative ways of getting home and perhaps even contact the police – the solution to the second scenario is found somewhere in a fog. Thanks to a dated, vaguely worded law on reporting client violations of the law, therapists and physicians regularly make their own judgment calls when such scenarios present themselves.

Section 203 of Ontario's Highway Traffic Act, created in 1966, demands mandatory physician reporting of "every person 16 years of age or over attending upon the medical practitioner for medical services who, in the opinion of the medical practitioner, is suffering from a condition that may make it dangerous for the person to operate a motor vehicle."

"Every time I work in the ER and put a cast on someone's arm, I should be writing a letter," says Dr. Elliot Halparin, president of the Ontario Medical Association (OMA). "The law is so all-encompassing that if you actually followed it, you'd swamp the ministry. It's an everyday problem."

For physicians and therapists with clients who have substance use problems, the legal web becomes even more tangled. "The difficulty then with substance abuse treatment is that substance abuse disorders may impair people's ability to operate vehicles," says Dr. David Marsh, clinical director of Addiction Programs at the Centre for Addiction and Mental Health (CAMH) in Toronto. "But if they know coming to treatment means they're automatically reported and they could lose their licence, that's a barrier to treatment," he adds.

To work with the law, many physicians make their own judgment calls, creating inconsistency

throughout the medical field. "Different physicians have taken different positions," says Marsh. "Many have felt that if somebody's coming to treatment regularly and doing well and makes a commitment not to drive impaired, they won't report them, although according to the letter of the law, they're obliged to. Others report everybody because, by the strictest reading of the law, that's what they ought to be doing," explains Marsh.

The OMA has worked to clarify the wording. In 1998, it developed recommendations accommodating mandatory reporting conditions and functional impairments. "Our recommendation was very clear that the mandatory reporting system would come from those conditions and list of functional impairments to be established by regulation," says Halparin. "We had a list of 10 mandatory reporting conditions. Then we carried on to say, 'You may report any other condition that might be a problem.'"

The OMA continues to reinforce to the Ministry of Transport the urgency of this law. Its recommendations were aided in the recent inquest into the death of 42-year-old Beth Kidnie, who was dragged to her death by an elderly driver. The essence of one of the inquest's recommendations is that the government change the law forcing physicians to report every client who shouldn't drive. Instead, the inquest recommended that the province, the OMA and other health care experts help create a diagnostic screening tool to focus on medically impaired drivers. Halparin also hopes that with a new health minister in place, he will be able to sit down with the minister face-to-face to press the issue.

While that's the issue for physicians, the issue for therapists is even more unclear, says Megan McCormick, a therapist with the Concurrent Disorders Service and Youth Service at CAMH. While physicians are legally obligated to report such impairments, it's not so clear for therapists. "A lot of the times when we're assessing a client, they might never see a physician," says McCormick. "As therapists, our concern is at what point do we need to be worried about a client and make it known to the physician that we have this information? We want to clearly know when physicians want to be alerted."

McCormick likens the conundrum to that faced by therapists and physicians in reporting clients to Children's Aid Societies when they are concerned about the safety of children. "As much as you want to support the client making changes and be patient and respectful of their goals, ultimately, if somebody's going to be hurt and possibly severely, what is our obligation?" asks McCormick. "In this case, not only could clients be putting themselves at risk, but numerous other unwitting people as well." While a more clearly worded provincial legislation is something that physicians and therapists hope for, McCormick hopes for something else.

"For therapists, we'd like some direction around the issue," she says. "If there was something more practically laid out, or if there was some kind of formulation to help us make decisions about the next steps, that would help." ■



A look at impaired driving in Canada

A report released in spring 2002 by Montreal-based Leger Marketing reports that 10% of Canadians said they have driven a vehicle after drinking alcohol exceeding the legal limit. Also, 79% noted that people in their social circle drive under the influence less often than they did a few years ago. Ten per cent said drinking and driving patterns have not changed among their friends and family, while 5% saw them drive while impaired more often.

The Canada Profile 1999, published by the Canadian Centre on Substance Abuse and CAMH, reports that among fatally injured drivers in 1996, 42% had some alcohol in their blood and 35% were over the legal limit.

Statistics Canada notes that the number of people in Canada charged with impaired driving in 1998 dropped 3.6% over the previous year, marking the 15th consecutive annual decline.

Who cares for the elderly?

Seniors suffer in an age of limited health care resources

BY LISA SCHMIDT

When Shakespeare said, "There is small choice in rotten apples," he could well have been prophesying some of the difficult decisions about who gets treatment in health care facilities and programs in the modern era.

Indeed, allocating health care resources when these resources are limited, inadequate, costly or inaccessible often comes down to making choices between what may appear to be the medical system's bruised fruits: poor service or no service.

Compound this with the prevailing stigma against the frail, the chronically ill and those with mental health or addiction issues and you have what Dr Michael Gordon, vice-president of medical services at the Baycrest Centre for Geriatric Care in Toronto, describes as "a world where demented, old people have no value and consequently may get no or inadequate treatment."

Resource allocation, the decision-making process that distributes health care programs and services, is rapidly emerging as the principle issue for health care administrators and governments everywhere, as costs escalate and funding for programs that affect the determinants of health, such as housing and employment, is lacking.

And how we care for the sick and frail will become a more pressing concern as our population ages and develops health care needs beyond what we are currently capable of handling. Already, in many jurisdictions, there is a shortage of care options for older persons no longer able to care for themselves. Some health care providers in the field of aging simply say: if you happen to be old and broke, you may literally be left out in the cold.

As the clinical co-ordinator for a program at the Centre for Addiction and Mental Health called OPUS 55 (OPUS being Older Persons, Unique Solutions) Margaret Flower agrees that the lack of services and programs for older adults is a huge problem. The program addresses the specific needs of people age 55 and over with substance use problems and age-related issues. Flower says there is no shortage of demand for services for this group. "It is completely unacceptable that as soon as a person gets old, they somehow no longer qualify for humane and compassionate treatment."

She cites the example of an older man who began drinking after the death of his wife eight years ago. He was in good health even though he wore a pacemaker. When it came time to replace the aging pacemaker, his doctor told him that he was no longer a good candidate due to his drinking, and was refused the replacement, even though that meant he would likely die when the old pacemaker broke down. Says Flower: "He said to me: 'I've been given a death sentence because I am old and I drink.' It was very difficult for me to watch him go through this: as a health care provider, I was appalled at what seemed to be a highly unethical decision based on financial, not ethical, responsibilities."

That these questions are profoundly ethical in nature is clear to those who advocate on behalf of older persons, particularly

those with mental health and addiction problems. Gordon says that there has been a tendency in health care to make ethical decisions from a purely utilitarian perspective. "Health care providers and administrators have a hard time using an ethical framework for decision-making, so they become 'practical,'" he says. "If this became a prevailing attitude, it could lead to a situation, for instance, where in a palliative care situation, a patient might be allowed to die more quickly to, in a 'practical' way, free up beds for others who are also dying."

Janet Chéné, director of long-term care at the Mount Hope Centre for Long Term Care in London, Ontario, has watched the trend to deinstitutionalize psychiatric clients into the community – including older adults who require intensive monitoring. She notes that some people fare better than others and that this often depends on what happens to be available when they need it.

"Some older adults who are discharged from psychiatric institutions to nursing homes actually do better in these environments," says Chéné. "There is a normalization of their routines, and there are often more social and recreational supports than where they came from."

But on the negative side, people are sometimes denied admission because their needs are so high. "A nurse may have to spend an hour in a hospital isolation unit getting an agitated client to take his medication in some cases, but we don't have the resources here to do that," says Chéné.

So what happens to these clients? Some end up right back at the psychiatric facility, says Chéné of clients who are difficult to treat, particularly ones with aggressive tendencies. But she notes that there are some hints that, at least in Ontario, people may soon have a place to go; the Royal Ottawa Hospital has received approval to build long-term beds for older people with psychiatric problems.

Reflecting on the state of care for older adults, Chéné adds: "The combination of being old and having a psychiatric illness places these clients in a very vulnerable position. We need to continue to work to convince those who control the resources that these people are just as important, deserving and valuable as anyone else." ■



Fast Facts

- By 2021, people 65 years and older will account for 18 per cent of the Canadian population, or 6.7 million people.
- Recent studies have shown that approximately 80 per cent of nursing home residents have at least one psychiatric disorder.
- Canada's health care spending is higher than ever before. In total, we spent \$102.5 billion to maintain or improve the health of Canadians (about \$3,300 per person). Most of this is spent on hospitals (32%) and medications (15%).

Q & A

Integrating ethics into the mental health and addiction fields



The following is based on an interview with Gordon DuVal. He is a bioethicist at the Centre for Addiction and Mental Health (CAMH) and the University of Toronto Joint Centre for Bioethics. He is also assistant professor with the Department of Psychiatry and the Faculty of Law at the University of Toronto. Previously, he worked in the clinical ethics department of the National Institutes of Health, a biomedical research centre in the United States.

What is the role of the bioethicist in mental health and addictions?

Bioethicists facilitate decision-making – they identify ethical problems, clarify dilemmas and analyze issues, weigh the moral consequences of various alternatives and suggest possible solutions. Clinical bioethicists provide consultations: people on a treatment or research team ask about particular ethical dilemmas that have arisen in practice. Sometimes staff merely need reassurance that what they are doing is ethically sound and a move forward. Bioethicists may also review policies and activities at their institution and may conduct research as the basis of formulating policies to guide clinical practice at their institution. They may also educate mental health and addiction professionals.

How has ethics become integrated into health care over the past few decades?

Bioethics is a relatively new field, although medical ethics has been around for a long time, at least since Hippocrates. The American Medical Association had a code of ethics in the 19th century. The first hospital-based ethics committee was in Seattle, Washington. Called the “God Committee,” its members would decide who would get life saving dialysis treatment for kidney disease – and who would die.

A strong religious element existed in bioethics in the early days, which still exists to some extent today. But philosophers affiliated with hospitals began to take over in the ’70s

and ’80s. At that time, there was a shift from paternalism toward autonomy – with greater focus on the client’s right to make self-regarding decisions. But bioethics still tends to be academic: law, philosophy and medicine remain the three primary feeder streams into bioethics.

Canadian and U.S. hospital accreditation requirements added a process for dealing with ethical issues. Hospitals began seeing the benefits of having a full-time staff bioethicist. While ethics committees already existed, none of the members were trained specifically in ethics. The ethics committee has drawbacks in what it can do, although members are certainly thoughtful and committed. Organizing, education and consultation are awkward for committees to do.

I think that hospitals see ethics as part of their scholarly mission to advance – the bioethicist should be a helpful service person, not distracted by any other job at the institution. The goal is to integrate ethics into good regular clinical practice. Bioethicists must think of the goals of the institution – to relieve suffering and heal the sick, which are fundamentally moral goals. Good clinical practice is ethical. The ethicist’s role is not to dictate, but to engage in discussion, to ask questions and discuss the values at stake.

What is the difference between a bioethicist and a client advocate?

There is some overlap between the role of the bioethicist and the client advocate. Sometimes client rights/interests are not being protected or are not being taken into account, so the ethicist must strive to identify those rights. But bioethicists aren’t client advocates per se. The bioethicist’s role isn’t necessarily to try to get clients what they want, but ultimately to strive to reach a consensus about an ethically acceptable way to move forward. Rights are certainly important for the less powerful who deal with the more powerful. But talking purely in terms of rights complicates matters by leading to

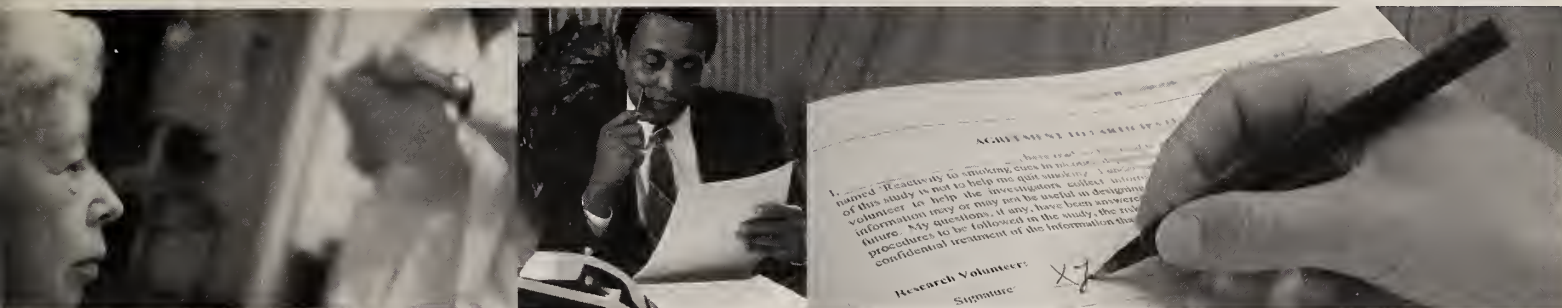
confusion about the nature of ethical obligations; rights imply that there are rules that must be followed no matter what. This takes away the richness of the values at play in a complex ethical dilemma.

What do you see as the core ethical issue in mental health and addiction?

Coercion is a core issue in mental health and addiction. Other ethical issues arise in determining decision-making capacity and when to give treatment without consent to a person who is incapable of making treatment decisions. When discussing capacity, we think of cognitive function – understanding information. But it’s not so simple. How does that fit with someone who has severe depression or who is impulsive? The problem isn’t that they have a cognitive impairment. They understand the information, but may make bad decisions without good justification in terms of their own values and what they really want. The same applies to eating disorders – the disorder affects decision-making. But is the client incapable? These people may be highly intelligent, but the nature of the disorder is such that their decisions may be based on distorted thinking. We can’t treat without consent. But then how do we take our role as caregivers and healers seriously?

What are some ethical issues integral to research and how can they be addressed?

Certain research designs create a greater risk for ethical problems, for example, placebo studies, which deprive ill people of the medication they may need. The ongoing risk is great, particularly with suicidal individuals. Washout studies, medication withdrawal studies and challenge studies are also controversial. The latter provoke symptoms through drugs or interventions. About three years ago, there was a controversy over ketamine challenge studies. Ketamine induces psychotic reactions, such as hallucinations. Is it acceptable to



conduct such studies because they will teach us a lot about the functioning of the brain? Does getting adequate consent from individuals who are fully voluntary and fully informed, and minimizing risks, then make it ethical to perform potentially controversial studies?

How has multiculturalism affected the way in which mental health and addiction workers need to approach ethical issues?

In addressing multiculturalism, we must be alive to two things: first, we must be aware that professional caregivers tend to come from the dominant culture, but clients often don't and may see things in different ways and have different ideas about decision-making and treatment. These differences often centre around concepts like autonomy. Our western culture has a very individualistic, self-determination orientation, which is reflected in our ethics, health care and structure of the law. We need to be open to ways of asking clients what their goals are, how they would like to be dealt with in terms of handling information and decision-making within families. We need to be alive to this need and not be scared to explore different ideas with clients.

Secondly, we need to be careful not to make assumptions about what people want based on their culture. Sometimes, depending on how long they've been here, individual temperament and so on, people might want to be dealt with in a different way than other people of their culture, so we must be careful not to generalize. This encourages us to have discussions, to keep an open mind about how people want to be dealt with.

The hard cases arise when we have very strong ideas about appropriate care that might conflict with those of another culture. The conflict is often seen as one where the individual's dignity and respect are at stake. Usually, we can accommodate cultural practices or differences. But tensions do sometimes occur about which we need to be open-minded.

What are some emerging ethical issues that will need to be addressed in the future?

I encounter many issues to do with coercion, which are manifesting themselves in new ways. There is a lot of formalized and informalized coercion in psychiatry – some of it is appropriate and some isn't. A recent issue that involves coercion is community treatment orders, whereby people with mental illness are allowed to live in the community in exchange for a commitment to receive and abide by treatment. Another ongoing issue is the stigma attached to mental illness and addiction. This becomes an ethical issue when we see how stigma interferes with getting appropriate care – getting access to necessary resources. Another issue I'd like to see more discussion about is the social and economic consequences of mental illness – such as access to housing and social services. The government doesn't see these as health care issues, but they really are. They affect an individual's well being.

Looking into the future, genetic issues will be very important, particularly the genetics of behaviours. The topic opens up a lot of issues that are distinct from those involved in diseases or based on disease models. What would we do if we could determine a genetic basis for various behavioural and personality traits – aggressiveness, niceness, sociability? Such knowledge would have important ramifications for society. If we can see what a pedophile's or a murderer's or a robber's brain looks like, this raises various questions about criminal and social responsibility. Once we have a physical picture of the physiology of what some of these traits are like, what do we do with that information? Will we put people in hospital instead of in prison? What does the genetic basis of behaviour say about our role in making choices? How will having strong scientific models for behaviours affect treatment decisions?

There are also implications that arise from the ability to predict vulnerability to a condition or disorder. What if we knew what a

pedophile's brain looked like and found that brain in a 16-year-old? And what about enhancement – if we could make people funnier, more charming, less nasty? If we have the ability to alter people's personality traits, would this technology be good for society or not?

Is our concern for ethical behaviour interfering with our obligation to provide care for clients?

It's a very difficult balance, and it's the core tension in medical ethics – beneficence versus autonomy – caring for someone versus respecting their choices. The tension really comes to the fore with psychiatric clients and we need to be alive to that tension. We can't say everything should be in favour of autonomy or in favour of beneficence. I think usually caregivers make good decisions if those values are present in their thinking. Coercion is in the same arena. For example, we are currently trying to put together a policy about giving medication to inpatients covertly. Is that practice acceptable? There are three choices: do nothing, force the client to take the medication or provide it to them covertly. No choice is ideal. Some will argue that giving medication might restore the client's capacity to make better decisions; therefore covert administration of the medication is seen as an autonomy restoring steps. But it's a difficult issue.

Caregivers are certainly more enlightened, the law is more enlightened, but we've got a long way to go in terms of addressing coercion – determining how acceptable it is and how much is acceptable. If it is acceptable, it should always be in the service of clients, not for the convenience of staff or for other reasons.

HEMA ZBOGAR

Reviews

The Belly of the Beast: Addiction up close and personal

MOVING. HUMAN. POIGNANT. PERSONAL. REAL.

These are words that come to mind in trying to describe Lorna Crozier and Patrick Lane's *Addicted: Notes from the Belly of the Beast*. "Required reading" is also a phrase that comes to mind, considering the vast array of journal articles and publications that advance the science and technology of addiction interventions, but lose sight of the human implications.

In these up close and personal essays, recognized literary and media figures take the reader inside their lives and experiences. The substances vary from the late Peter Gzowski's warm and witty description of his struggle with nicotine to Patrick Lane's literary and almost poetic description of destruction wreaked by alcohol to Stephen Reid's gritty recounting of the depths of heroin use.

The perspectives also vary. Marnie Woodrow provides a sad and heart-wrenching description of addiction from both the child's perspective and the user's perspective, while Lorna Crozier writes from the viewpoints of the child, the wife and the user.

Regardless of the viewpoint and the substance of choice, these two threads woven throughout *Belly of the Beast* exemplify excellent writing, providing a view of addiction from the inside out. The essays capture the essential nature of a variety of slides people use to spiral into dependency and the depths of addiction. They also capture the range of loss, betrayal, abuse and humiliation experienced by and perpetrated by the user. In many of the essays, the honesty and objectivity clearly and simply present a reality of experience with a depth of understanding and no excuses. In most, too, there is a message of hope. A message that life can be different and more livable. Indeed, David Adams Richard, one of the contributors to the book, was a recipient of the 2002 Courage to Come Back Award, which celebrates the courage of individuals who are overcoming the challenges of living with a serious illness, injury or addiction.

For those working in the addiction field or experiencing their own recovery, the essays will ring familiar. We have heard these stories a hundred or a thousand times. We have heard of the lost jobs, lost opportunities, lost relationships. We have heard of the broken promises, broken dreams, broken people. There is a sameness and a repetition of experience. This sameness, this shared experience of repeating patterns with their own individualized twists speaks to the value people find in group work, and in supports like Alcoholics Anonymous and Narcotics Anonymous.

By the middle of *Belly of the Beast*, a feeling of déjà vu surfaces. Readers might think, "I've heard this all before" and wonder whether they really want to read yet another story. However, like the experience of hearing people speak their stories in person, the richness of the book comes from the detail and the individual twists to the common patterns.

There are also lessons and wisdom embedded in each perspective. *Belly of the Beast* could be a valuable addition to one's treatment and recovery experience and to a clinician's or program's library. There is shared experience. There is grief and sadness. And there is good advice. This is not an enjoyable book to read; it is a worthwhile book to read.

DENNIS JAMES is director of Clinical Operations at CAMH. He is also an educator and administrator, serving for more than 27 years in the addictions field.

Addicted: Notes from the Belly of the Beast. ed. Lorna Crozier and Patrick Lane. Greystone Books, Vancouver, 2001. 192 pp., \$22.95.

Psychiatry in Canada: A cooler Canadian take

IT IS A MEASURE OF HOW MUCH HAS CHANGED IN CANADIAN psychiatry that of the 29 authors in this volume, 13 are from Toronto and only two are from Montreal – and those are francophone psychiatrists. Fifty years ago, when psychiatry began to establish itself in Canada, the scene was entirely dominated by McGill University and its affiliated Allan Memorial Institute. Names such as Heinz Lehmann soon became household words around the world. Toronto and other centres were mere specks on the horizon.

Psychiatry in Canada: 50 Years (1951 to 2001) is a lovely little book, adorned with photos from Canada's psychiatric past. It does not really point to any researchers who are household names today, but at least we see how much the many different Canadian centres have accomplished over the past five decades.

There are strengths and weaknesses among the 16 contributions. Editor Quentin Rae-Grant has tried to draw from fields as disparate as medical economics and genetics. His authors cover the waterfront: Molyn Leszcz on psychotherapy in Canada and John Leverette and Emmanuel Persaud on postgraduate education. Cyril Greenland offers a well-researched overview of the evolution of psychiatry as a discipline in this country, as opposed to many of the authors, who tend to produce pladoyers for their fields rather than histories of it.

The terrifically useful piece by Kathy Hodgkinson and Anne Bassett on the history of genetics might be singled out because it offers a table showing chief moments in the entire evolution of genetics and psychiatric genetics from 1850 to the present. The two authors make clear the significance of distinctively Canadian contributions and casually drop a number of absolutely charming literary quotations showing that people have always appreciated the importance of the genetic transmission of illness.

Frédéric Grunberg writes in French on "50 Years of Psychiatry in Quebec." George Awad has an article on psychopharmacology research showing how significant Canadian investigators have been in the international narrative. He gives us a table of notable bright points in psychopharmacology today, but does not really point out how remarkable historically the contributions from French Canada have been. R.C. Bland and co-authors present quite an exhaustive treatise on psychiatric epidemiology in Canada, with 182 references.

David Goldbloom and Paul Garfinkel conclude with some thoughtful observations about the future. One last comment: It would have been splendid to have a chapter placing Canadian contributions in some kind of international perspective. For a country of about 30 million, how well have we been doing? Has all the money we have spent on research paid off?

The Canadian Psychiatric Association can be proud at how well this collection has turned out: modest, exact and not full of bombast about "our achievements," unlike a recent counterpart volume of the American Psychiatric Association. Very Canadian.

EDWARD SHORTER is a professor of the history of medicine and a professor of psychiatry at the University of Toronto. Among his recent books are *A History of Psychiatry from the Era of the Asylum to the Age of Prozac* and *The Triumph of Psychopharmacology and the Story of CINP*.

Psychiatry in Canada: 50 Years (1951 to 2001), 2nd ed. Ed. Quentin Rae-Grant. Canadian Psychiatric Association, Ottawa, 2001, 320 pp., \$16.

Eating Disorders and Obesity: A comprehensive guide to a growing problem

THE PREVALENCE OF OBESITY IN BOTH CHILDREN AND ADULTS IS rising quickly worldwide and is among the most troublesome health problems considered by the World Health Organization. Indeed, the demand for treatment for eating disorders has increased in recent years. These conditions are associated with numerous physical and psychosocial problems, about which researchers and clinicians need accessible and succinct information. The need to synthesize all this information in one volume resulted in the second edition of *Eating Disorders and Obesity: A Comprehensive Handbook*, which accomplishes its goal commendably.

The handbook contains 112 brief chapters, which are divided into three main sections: 1) Foundation, 2) Eating Disorders and 3) Obesity. Experts in each field have contributed to the discussion, which flows elegantly from physical to social factors. Factors related to the regulation of eating and body weight are presented, as well as psychological and social factors of dieting and body image, measurement methods, clinical characteristics, epidemiology, etiology, prevention and medical and physical aspects of these conditions. The contributors discuss various treatments, including medication and therapies that range from the most to the least professionally guided ones (cognitive behavioural therapy to self-help).

In addition to providing new and authoritative information, the goal of the editors is to strengthen the connections between eating disorders and obesity. This is accomplished by cross-referencing various chapters and presenting issues shared by eating disorders and obesity. The first issue discussed relates to basic physiology, the psychology of hunger and satiety and processes underlying weight regulation. Other issues include binge eating, body image and cognitive behavioural therapy.

This second edition is not merely an update of the first edition. Although it has kept the short chapters, topics and contributors of the original edition, the editors have attempted to create links between the areas of eating disorders and obesity by: 1) addressing the topics common to the areas; 2) addressing the expended processes underlying control of eating and weight; 3) cross-referencing the different sections of the book; 4) introducing new topics such as molecular genetics, leptin and binge eating disorder; and 5) providing new knowledge, understanding and practice.

Despite cross-references and the first section of the book, which presents topics shared by eating disorders and obesity, other material is still presented sequentially and greater integration would have strengthened the book. The brevity of the chapters may at times appear like a presentation of numerous facts that lack depth, and the reader may be eager to know more. This is a logical drawback of the format.

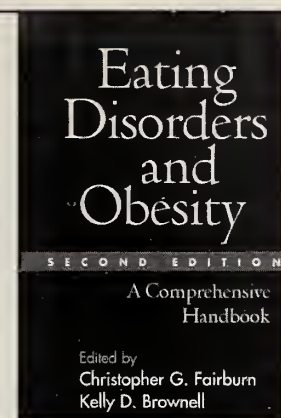
Unlike most scholarly books, *Eating Disorders and Obesity* does not contain in-text references. The editors suggest that this format helps authors to synthesize their knowledge based on clinical and research observations instead of referring to numerous studies as is common in most textbooks. While this format simplifies reading, the reader interested in investigating a statement cannot directly trace the specific studies on which the argument is based. However, a list of suggested readings is provided at the end of each chapter, which somewhat remedies this problem.

In addition to discussing new information related to traditional areas such as biology, clinical characteristics and treatment and prevention, the handbook addresses interesting and at times controversial issues such as the Internet, night eating syndrome, eating and addictive disorders, personality, childrearing, diversity, gender, ethnicity, occupation, dieting, stigma and discrimination.

This scholarly synthesis of knowledge reflects high-quality writing and editorial work, and is a must-have for researchers and academics and for clinicians involved in the care of clients with eating disorders and/or obesity.

CHRISTINE COURBASSON is head of the Eating Disorders and Addiction Clinic at CAMH. She is also an assistant professor in the Department of Psychiatry at the University of Toronto.

Eating Disorders and Obesity: A Comprehensive Handbook. Christopher G. Fairburn and Kelly D. Brownell, eds. Guilford Press, New York, 2001, 623 pp., \$65 US.



Downloaded

Numbers on the Net

The Internet has become an expedient, cost-effective means of disseminating statistical reports for government and public organizations. Here are some current releases.

Tobacco or Health in Ontario

Available at Cancer Care Ontario, www.cancercare.on.ca

This comprehensive report focuses on the impact of tobacco use on the health and mortality of Ontarians over the past 50 years, with projections to 2050. Although the emphasis is on cancer, other tobacco-related diseases are covered. Health topics include comparative data with non-tobacco-attributed mortality and gender differences in mortality trends, which have peaked for males but are still on the increase for females. The report points out that Ontario has the lowest cigarette prices in Canada. Scenarios of mortality reduction are projected based on three sample cigarette price increases.

Proportions of Crimes Associated with Alcohol and Other Drugs in Canada
Available at the Canadian Centre on Substance Abuse, www.ccsa.ca

Several sources of data were used in this study to investigate a causal, quantifiable link between substance use and crime. To date, there has been little Canadian data on this topic, although evidence has supported an association. This study lays the groundwork for future research.

The Canadian Community Health Survey (CCHS), 2000–2001

Soon to be released and available at Statistics Canada, www.statcan.ca

The Canadian Community Health Survey is a new Canada-wide population survey that will be conducted at regular intervals to collect information about health determinants (e.g., smoking and drinking), health status (e.g., stress and mental health) and health system use. Data will be broken down by 133 health regions across Canada.

SHEILA LACROIX

The Last Word

Safe injection facilities: Canada's ethical and legal obligations

BY RICHARD ELLIOTT

INJECTION DRUG USE PRESENTS A GROWING HEALTH CRISIS FOR Canada. People who inject drugs face serious potential health risks, including overdoses and blood-borne diseases such as HIV/AIDS and hepatitis C. One partial solution is the establishment of "safe injection facilities" (SIFs).

At SIFs, drug users are legally able to inject using clean equipment under the supervision of medically trained personnel. SIFs are not "shooting galleries," which are not legally sanctioned, are often unsafe, do not offer hygienic conditions or sterile equipment and lack access to health services. The drugs are not provided by the facility, nor do staff help administer the drugs. SIF staff help users minimize the risk of overdose, disease or other negative health effects that may result from using unclean equipment and unsafe injecting practices. They provide free sterile equipment, including syringes, alcohol, dry swabs, water, spoons/cookers and tourniquets. SIFs also direct clients to treatment and rehabilitation programs, and operate as primary health care units.

The arguments against SIFs are generally ill conceived or overstated, and are outweighed by the likely benefits. One argument claims that SIFs condone or encourage drug use. This claim is based on the false premise that a strict abstinence-oriented approach contains drug use, and that relaxing prohibition would yield greater drug use. In fact, SIFs actually extend the pro-health message of needle exchange programs (NEPs), which are widely recognized as a positive harm reduction measure.

Nonetheless, NEPs are a half-hearted approach: staff provide sterile injection equipment, but tell the person to go elsewhere to inject, despite all the evidence of the risks that follow. This is bad health practice and policy. SIFs go further, offering a safe, hygienic place to inject, with access to medical intervention and other health and social services. This is a positive message of concern for drug users' health.

Some opponents claim that SIFs are a trouble magnet. But SIFs offer the greatest promise if set up where there is already a need. In fact, it is precisely in such high-use settings that SIFs can benefit the broader community as well, by reducing the public nuisance associated with existing (quasi)-public drug scenes (e.g., discarded needles).

The evidence lends support to experimenting with SIFs. The experiences of countries such as Switzerland, Germany, the Netherlands and Australia suggest that including SIFs as part of a broader policy response will likely benefit both drug users and communities.

Given the existing harms, and the potential of SIFs to eliminate or reduce some of these dangers, the ethical imperative is clear. So what does the law say?

Under international law, Canada must take proactive measures (particularly legislative) to progressively realize everyone's right to the highest attainable standard of health. Canada must aim to prevent, treat and control disease and to assure equal access to medical services in the event of illness. Failure to facilitate SIFs' operation arguably amounts to a violation of Canada's obligations.

The drug control treaties signed by Canada do not preclude the establishment of SIFs. They include provisions that, with political will, can

easily be interpreted to allow such harm reduction initiatives.

Canadian law also does not prevent the implementation of SIFs. Concerns about civil liability for injuries of clients or staff are no different than those applying to other health facilities. Criminal law does not directly prohibit SIFs, although clients and staff face the potential for charges of possession of controlled substances, aiding or abetting possession or distributing drug paraphernalia. The risks are minor but should be addressed. Canadian law contains provisions that could be used to create a regulatory framework governing the fully legal operation of SIFs.

Canada's Drug Strategy is premised on preventing harm. SIFs are one important component of a comprehensive strategy. Canada cannot sit idly by, refusing to implement reasonable measures shown to be effective in other countries, while HIV, hepatitis C and other preventable harms continue.

The Canadian HIV/AIDS Legal Network, a non-governmental human rights organization working on legal and policy issues relating to HIV/AIDS, has made a number of recommendations for action.

- First, the federal government should update Canada's Drug Strategy to expressly support SIF trials.
- Second, the federal government should create a regulatory framework under the Controlled Drugs and Substances Act (CDSA) to govern SIFs, setting out criteria to be met in order to be exempt from criminal prohibitions.
- Third, the regulatory framework should address such issues as the conditions of access to the facility, activities and services permitted on the premises and minimum administrative requirements aimed at ensuring the facilities' safe and effective operation.
- Fourth, while developing that regulatory framework, the federal minister of health should grant ministerial exemptions from the provisions of the Controlled Drugs and Substances Act that make it an offence to possess a controlled substance in designated SIFs (and NEPs). These would apply to SIF staff and clients to allow such facilities to operate on a trial basis.
- Fifth, Health Canada should fund the operation and evaluation of a multi-site scientific research trial, including assessing the impact of SIFs on the well being of drug users, the public health generally and specific communities.
- Finally, federal, provincial/territorial and municipal officials with responsibilities in the areas of health, social services and law enforcement should collaborate to ensure trials of safe injection facilities occur as soon as possible. ■

Richard Elliott is a lawyer with the Canadian HIV/AIDS Legal Network.

For more information: *Establishing Safe Injection Facilities in Canada: Legal & Ethical Issues* is available on the Canadian HIV/AIDS Legal Network Web site at www.aidslaw.ca, or through the Canadian HIV/AIDS Clearinghouse, tel (613) 725-3434, fax (613) 725-1205, e-mail aidsida@cpha.ca.

Editorials do not necessarily reflect the views of CAMH. We welcome submissions from our readers. For information, contact: The Editor, *The Journal of Addiction and Mental Health*, 33 Russell St., Toronto, Ontario M5S 2S1 tel (416) 595-6714 e-mail hema_zbogar@camh.net

Conferences

CANADA

46th Annual Meeting of the American Association of Children's Residential Centres

October 16-19
Vancouver, British Columbia
tel (301) 738-6460
fax (301) 738-6461
e-mail info@aacrc-dc.org
web www.aacrc-dc.org

52nd Annual Meeting of the Canadian Psychiatric Association

October 31-November 3
Banff Springs, Alberta
Contact: CPA Head Office, 260-441
MacLaren St., Ottawa, ON K2P 2H3
tel (613) 234-2815
fax (613) 234-9857
e-mail agm@cpa-apc.org

Annual Scientific Meeting of the Canadian Academy of Geriatric Psychiatry

November 4, Banff, Alberta
Contact: Dr Lilian Thorpe,
Saskatoon City Hospital, 701 Queen St.,
Saskatoon, SK S7K 0M7
tel (306) 655-7997
fax (306) 655-7995
e-mail thorpe@sdh.sk.ca

Annual Meeting of the Canadian Academy of Child Psychiatry

November 3-5, Banff, Alberta
Contact: Elizabeth Manson
tel (416) 813-6540
e-mail elizabeth.manson@sickkids.on.ca

Fourth Annual Energy Psychology Conference - New Horizons in Energy Psychology

November 7-9, Toronto, Ontario
Contact: Dr. Sharon Cass Toole,
Meridian Psychotherapy Services
tel (416) 221-5639
fax (416) 221-7126
e-mail sharon@meridianpsych.com
web www.meridianpsych.com/epc.htm

Annual Winter Conference of the Canadian Academy of Psychiatry and the Law

March 3-6, 2003, Whistler,

British Columbia
Contact: Dr. Dominique Bourget
tel (613) 722-6521 ext. 6366
e-mail thira@sympatico.ca
web www.capl.net

83rd Annual Convention of the Western Psychological Association

May 1-4, Vancouver, British Columbia
Contact: 5929 Westgate Blvd., Ste. C,
Tacoma, WA 98406
tel (253) 752-9838
fax (253) 752-9829
e-mail pannen.wpa@worldnet.att.net

63rd Annual Scientific Meeting of the College on Problems of Drug Dependence

June 8-13, Quebec City, Quebec
Contact: Dr. Martin W Adler,
Executive Officer, CPDD, Department of
Pharmacology, 3420 North Broad St.,
Philadelphia, PA 19140
tel (215) 707-3242
fax (215) 707-1904
e-mail baldeagl@vm.temple.edu

Annual Winter Conference of the Canadian Academy of Psychiatry and the Law

March 3-6, 2003, Whistler,
British Columbia
Contact: Dr. Dominique Bourget
tel (613) 722-6521 ext. 6366
e-mail thira@sympatico.ca
web www.capl.net

UNITED STATES

49th Annual Meeting of the American Academy of Child and Adolescent Psychiatry

October 22-27, San Francisco, California
Contact: Julie Morgan, American
Academy of Child and Adolescent
Psychiatry, 3615 Wisconsin Ave., NW,
Washington, DC 20016-3007
tel (202) 966-7300
fax (202) 966-2894

33rd Annual Meeting of the American Academy of Psychiatry and the Law

October 24-27, Newport Beach, California

Contact: 1 Regency Dr., PO Box 30,
Bloomfield, CT 06002-0030
tel (860) 242-5450
fax (860) 286-0787
e-mail execoff@aapl.org

36th Annual Convention of the Association for Advancement of Behavior Therapy

November 14-17, Reno, Nevada
Contact: Association for Advancement of
Behavior Therapy, 305 Seventh Avenue,
16th flr, New York, NY 10001-6008
tel (212) 647-1890
fax (212) 647-1865
web www.aabt.org/

43rd Psychonomic Society Annual Meeting

November 21-24, Kansas City, Missouri
Contact: 1710 Fortview Rd.,
Austin, TX 78704
tel (512) 462-2442
fax (512) 462-1101
e-mail rsanford@psychonomic.org
web www.psychonomic.org/meet.htm

4th National Harm Reduction Conference - Taking Drug Users Seriously

December 1-4, Seattle, Washington
Contact: Conference Coordinator, Harm
Reduction Coalition, 22 West 27th St.,
5th flr, New York, NY 10001
tel (212) 213-6582
e-mail conference@harmreduction.org
web harmreduction.org/conference/4thnatlconf.html

Hazelden Foundation - Faculty Training Program on Addiction for Primary Care Physicians

December 2-6, West Palm Beach, Florida
Contact: Anne Fitzgerald,
15245 Pleasant Valley Rd., PO Box 11,
Center City, MN 55012-0011
tel (212) 420-9522 ext. 145
e-mail afitzgerald@hazelden.org
web info@hazelden.org

American Academy of Addiction Psychiatry - 13th Annual Meeting & Symposium

December 12-15, Las Vegas, Nevada
Contact: AAAP, 7301 Mission Rd.,

Suite 252, Prairie Village, KS 66208
tel (913) 262-6161
fax (913) 262-4311
e-mail info@aaap.org
web www.aaap.org

American Psychoanalytic Association's 91st Annual Fall Meeting

December 13-22, New York, New York
Contact: American Psychoanalytic
Association, 309 East 49th St.,
New York, NY 10017
tel (212) 752-0450
fax (212) 593-0571
e-mail central.office@apsa.org

International Neuropsychological Society Continuing Education Program

February 5-8, 2003, Honolulu, Hawaii
Contact: INS, 700 Ackerman Rd.,
Ste. 550, Columbus, OH 43202
tel (614) 263-4200
fax (614) 263-4366
e-mail osu_ins@postbox.acs.ohio-state.edu
web www.osu.edu/ins/meetinfo.html

American Group Psychotherapy Association Annual Meeting

February 18-23, New Orleans, Louisiana
Contact: AGPA, 25 East 21st St.,
6th flr., New York, NY 10010
toll-free (877) 668-2472
tel (212) 477-2677
fax (212) 979-6627
e-mail info@agpa.org

61st Annual Scientific Meeting of the American Psychosomatic Society

March 5-8, Phoenix, Arizona
Contact: 6728 Old McLean Village Dr.,
McLean, VA 22101
tel (703) 556-9222
fax (703) 556-8729
web info@psychosomatic.org

Society for Research in Child Development Biennial Meeting

April 24-27, Tampa, Florida
Contact: SRCD, 505 East Huron,
Ste. 301, Ann Arbor, MI 48104-1567

Cont'd...

tel (734) 998-6578
fax (734) 998-6569
web srcd@umich.edu

**American Psychiatric Association
Annual Meeting**

May 17–22, San Francisco, California
Contact: APA Office of International
Affairs, 1400 K Street NW,
Washington, DC 20005
tel (202) 682-6000
fax (202) 682-6850
e-mail apa@psych.org

**Assessment and Treatment of
Chemical Dependency: A Practical
Approach**

June 24, Los Angeles, California
Contact: Professional Psych Seminars, Inc.,
PO Box 1144, Agoura Hills,
CA 91376-1144
toll-free (877) 777-0668
tel (805) 371-9443
fax (805) 371-7443

Institute on Psychiatric Services

October 29–November 2,
Boston, Massachusetts
Contact: APA Office of International
Affairs, 1400 K Street NW,
Washington, DC 20005
tel (202) 682-6000
fax (202) 682-6850
e-mail apa@psych.org

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tel (212) 477-2677
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e-mail info@agpa.org

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March 5–8, Phoenix, Arizona
Contact: 6728 Old McLean Village Dr.,
McLean, VA 22101
tel (703) 556-9222
fax (703) 556-8729
web info@psychosomatic.org

ABROAD

**World Federation for Mental Health
Biennial Congress**

February 21–26, 2003, Melbourne,
Australia
Contact: Secretariat, ICMS Pty Ltd.,
84 Queensbridge St., Southbank,
Victoria, Australia 3006
tel 61 3 9682 0244
fax 61 3 9682 0288
web www.icms.com.au

**The Second Expert Review of
Bipolar Disorders**

March 21–23, Maastricht, The Netherlands
Contact: Russell Pendleton
tel 44 115 969 2016
web www.expertreview.org

**6th Workshop on Costs and
Assessment in Psychiatry – "Mental
Health Policy and Economics:
The Value of Research"**

March 28, Venice, Italy
Contact: International Center of
Mental Health Policy and Economics,
Via Daniele Crespi 7, 20123 Milan, Italy
tel 39 02 5810 6901
fax 39 02 5810 6901
e-mail info@icmpe.org
web www.icmpe.org

**10th Biennial Conference of
the International Society for
Theoretical Psychology**

June 22–27, Istanbul, Turkey
Contact: Dr. Aydan Gulerce, Chair,
ISTP2003 Organizing Committee,
Bogazici University, Bebek, Istanbul,
80815, Turkey
fax (90) 212 257 5036
e-mail istp2003@boun.edu.tr

**8th European Congress of
Psychology – Psychology in
Dialogue with Related Disciplines**

July 6–11, Vienna, Austria
Contact: Monika Glantschnig, EFPPA
2003 Committee, Austrian Professional
Association of Psychologists,
Möllwaldplatz 4/4/39,
A-1040 Vienna, Austria
tel 43 1 407 26 71 17
fax: 43 1 407 26 71 30
e-mail info@psycongress.at
web www.psycongress.at

**2nd International, Interdisciplinary
Conference on Psychology & Law**

July 7–12, Edinburgh, Scotland
Contact: David Carson, Faculty of Law,
University of Southampton, Southampton,
Hampshire, SO17 1BJ, United Kingdom
e-mail D.C.Carson@soton.ac.uk
web www.law.soton.ac.uk/bsln/
psych&law2003/

**International Brain Research
Organization 6th Congress of
Neuroscience**

July 10–15, Prague, Czech Republic
Contact: Secretariat, Secretariat, 6th
IBRO World Congress of Neuroscience,
Guarant Ltd., Opletalova 15, 110 00
Prague 1, Czech Republic
tel 420 2 24 21 06 50
fax 420 2 24 21 21 03
e-mail ibro@wanadoo.fr

**28th Interamerican Congress
of Psychology**

July 13–18, Lima, Peru
Contact: Dr. Cecilia Thorne,
e-mail cthorne@pucp.edu.pe
Dr. David Jauregui,
e-mail davidja@terra.com.pe

web www.sip2003.org and
www.am.org/sipsych

16th International Hypnosis Congress

August 2–8, Singapore
Contact: Secretariat, ICMS Pty Ltd.,
84 Queensbridge Street, Southbank,
Victoria, Australia 3006
tel 61 3 9682 0244
fax 61 3 9682 0288
web www.icms.com.au/

**VIII World Congress of
Biological Psychiatry**

September 28–October 3,
Buenos Aires, Argentina
Contact: WCBP 2003 Congress
Secretariat, Congresos Internacionales
S.A., Moreno 584, 9th flr. (1091),
Buenos Aires, Argentina
tel 54 11 4342 3216/3408
fax 54 11 4331 0223/4334 3811
e-mail conginte@congresosint.com.ar

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